Burnaby Hospital Hip & Knee Arthroplasty Centre Referral

Patient Name **M F DOB**

Care Card #

Address

Patient Phone Home	**Cell**	**Work**	**Speaks:** ☐ English ☐ Other:
Referring Practitioner Name:		**Phone:**	**FAX**

COMPLETE ALL RELEVANT FIELDS. ATTACH MEDICAL HISTORY/ MEDICATION LIST.
FAX TO 604-419-1418

INCOMPLETE REFERRAL WILL NOT BE PROCESSED.

Reason for referral:

☐ First available surgeon (recommended). Or ☐ Specify surgeon:_________________________

Affected joint (s): Knee: ☐ Right ☐ Left ☐ Bilateral Hip: ☐ Right ☐ Left ☐ Bilateral

Attach X-rays as specified of the affected joint (s) (done within 3 months) ☐ Available on PACS

☐ Knee: 1. Weight bearing AP of both knees 2. Lateral bent knee of affected side 3. Skyline of affected side

☐ Hip: 1. AP Pelvis including proximal 1/3 of femurs 2. True lateral of affected hip

Pain with walking:
☐ None/Mild ☐ Moderate ☐ Severe

Loss of flexion, extension or joint stability
☐ None/Mild ☐ Moderate ☐ Severe

Walking tolerance <u>without</u> significant pain:
- ☐ Over 5 blocks
- ☐ 1 to 5 blocks
- ☐ Less than 1 block
- ☐ Household

Mobility aids used: ☐ Cane ☐ Crutches ☐ Walker ☐wheel chair.

☐ ***Unable to work, care for others or requires assistance with daily living related to affected joint**.

☐ **Pain at rest (sitting, lying down, sleeping).**
How many nights a week is sleep disturbed? _________

☐* **Has both ongoing pain with motion and at rest**

Treatments Trialled
- ☐ Physio therapy
- ☐ Specialized exercise
- ☐ Joint injections.

Other:

Analgesics**:**
- ☐ PRN Tylenol/NSAID
- ☐ Scheduled Tylenol /NSAID
- ☐ PRN Opioids
- ☐ Scheduled Opioids

☐ Concerns regarding an insitu arthroplasty. Specify:_____________________________________

Height____**Weight**______ **BMI** _____ **Medical concerns** ☐ None ☐ Mild or past significant problem ☐ Constant significant, difficult to control. **Mental health:** ☐ Active Depression ☐ **Other comments**:

Signature. Referring Practitioner____________________ Date: DD/MM/YY ___________________

For Burnaby Hip/Knee Centre USE ONLY

☐ * **Requires urgent** surgeon consult:

	Date	Time	Initials
☐ Received referral from Referring Practitioner (RP)			
☐ Surgeon appointment date ____________Patient notified.			
☐ If surgeon specified, patient & RP notified of this consult date & first available date			
☐ Not a surgical candidate. Care plan to patient. Letter/Care plan to RP			