Cape Breton District
HEALTH AUTHORITY
Making Healthier Choices Together

Sample, Patient
123 Main St.
Apt. 218
Dartmouth, NS
B2B 2B2
(902) 555-0248
DOB: 1949/03/14
HCN: 0000 000 000

OAC Hip and Knee Referral Form

THE FOLLOWING MUST BE COMPLETED PRIOR TO SENDING REFERRAL:
ATTACHED RADIOGRAPHIC REPORT (COMPLETED IN THE LAST 6 MONTHS)
KNEE VIEW: WEIGHTBEARING AP/LAT WITH SKYLINE PATELLA
HIP VIEW: AP PELVIS WITH AP/LAT AFFECTED SIDE

PLEASE FAX TO – 563-8572

REFERRAL REQUEST:

❑ 4-Week Hip & Knee Management Program ONLY
-OR-
☒ Orthopaedic Surgeon Assessment + 4-Week Hip & Knee Management Program

PLEASE ALSO SELECT: ☒ Next Available Surgeon **-OR-** Specific Surgeon:
❑ Dr. D. Brien ❑ Dr. K. Orrell
❑ Dr. F. Dodd ❑ Dr. M. O'Neill

REASON FOR REFERRAL – AFFECTED JOINT(S):

❑ Left Hip ☒ Right Hip History of Injury and/or Trauma? ☒ Yes ❑ No
❑ Left Knee ☒ Right Knee
**Does not include acute ligamentous injuries or revision arthroplasty
(Those referrals should continue to be sent directly to surgeon's office)

ADDITIONAL PATIENT INFORMATION:

Please check the box that most accurately describes the patient's situation over the last three months:

1. Ability to walk without significant pain: ❑ Unlimited ☒ 1-5 blocks ❑ <1block ❑ Household only
2. Highest level of walking support (**related to affected joint(s)**) the patient currently uses to carry out usual activities: ❑ None ☒ Brace/Cane ❑ Walker ❑ Wheelchair
3. Duration of symptoms: ❑ 0-6 Months ☒ 6-12 Months ❑ >12 Months
4. Pain during: Rest ☒ Intermittent ❑ Constant
   Activity ❑ Intermittent ☒ Constant
   Night ☒ Intermittent ❑ Constant

Non-Operative Treatment to Date: ☒ NSAIDS ☒ Physiotherapy ❑ Depo-medrol Injections ☒ Lifestyle

PMHx/Medications: ***Mauris et lectus posuere, interdum odio vel, ultrices diam. Nunc tortor enim, feugiat eu rutrum in, ultricies quis augue. Curabitur vulputate libero elementum mauris pellentesque sagittis. Quisque nec nunc nec metus dignissim aliquet. Aenean aliquet accumsan sapien. Donec dapibus nulla egestas lectus egestas, in dictum dolor scelerisque. Maecenas vel tortor rutrum, pulvinar sem id, feugiat augue. Interdum et malesuada fames ac ante ipsum primis in faucibus. In mollis non mi et lobortis. Aenean lectus urna, fermentum ac tellus quis, lacinia malesuada lectus. Integer in port.***

Physician/Referring Provider Signature: _____ Date: *2014/03/21*
DR. REQUESTING PHYSICIAN