Vancouver CoastalHealth

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Vancouver Acute
Complex Joint Clinic (CJC) &
Arthritis Surgical Assessment Program (ASAP)

HIP AND KNEE REPLACEMENT REFERRAL FORM (2 pages)

All referrals will be seen by an advanced practice physiotherapist for screening and if surgery is needed will be seen by the surgeon. Please indicate your preference for surgeon. Wait times my vary by surgeon.

☐ Dr. B. Masri ☐ Dr. D. Garbuz ☐ Dr. N. Greidanus ☐ Dr. L. Howard ☐ Dr. M. Neufeld ☐ First available

BILLABLE TO: ☐ MSP ☐ ICBC ☐ WCB ☐ PATIENT ☐ OTHER	NAME / ADDRESS OF REFERRING PHYSICIAN AND MSP PRACTITIONER # (or office stamp)
PERSONAL HEALTH NUMBER: / DOB: YYYY /MM/DD	
SURNAME OF PATIENT, FIRST NAME AND MIDDLE INITIAL	
TELEPHONE# (INCLUDE AREA CODE): / ☐ MALE ☐ FEMALE ☐ OTHER PREGNANT: ☐ YES ☐ NO	FAX#:
EMAIL:	
ADDRESS CITY/TOWN POSTAL CODE	~~COPY RESULTS~~ TO:

☐ TRANSLATION SERVICES REQUIRED: (PLEASE INDICATE LANGUAGE): _____
(24 HOUR ADVANCED NOTICE REQUIRED)

REASON FOR REFERRAL

JOINT: ☐ HIP ☐ KNEE **SIDE:** ☐ RIGHT ☐ LEFT ☐ BOTH

- **FOR ALL REFERRALS: PLEASE INCLUDE A BRIEF HISTORY AND ATTACH ANY RECENT BLOOD/LAB OR PERTINENT CONSULTS/ RESULTS**
- **ALL REFERRALS MUST INCLUDE AN X-RAY REPORT (RECENT OR WITHIN 1 YEAR)**

OUR FACILITY IS A FRAGRANCE FREE ZONE

PLEASE PRINT CLEARLY

☐ **ALLERGIES (PLEASE LIST):** _____

_____

_____

☐ **MEDICATIONS (PLEASE LIST):** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT HEIGHT: _____ **WEIGHT:** _____

HAS THE PATIENT HAD PREVIOUS HIP / KNEE ARTHROPLASTY: ☐ **YES** ☐ **NO**

SURGEON NAME: _____

- **IF YES, PLEASE ATTACH:**
  - **OPERATIVE REPORTS FROM THAT SURGERY AND IMPLANT LABELS**
  - **IF NO RECENT BLOOD WORK, PLEASE ORDER A CRP BLOOD TEST**
- **THIS REFERRAL MUST BE RELATED TO SURGICAL CONSULTATION FOR HIP AND/OR KNEE REPLACEMENT**

WE SEE PATIENTS FOR THE FOLLOWING:

- OSTEOARTHRITIS, HIP DYSPLASIA, FAILED ARTHROPLASTY (REVISIONS), AVASCULAR NECROSIS.

WE <u>DO NOT SEE</u> PATIENTS FOR:

- SOFT TISSUE INJURIES, MENISCAL TEARS, ACL, BUNIONS, SHOULDERS, ANKLES, OR SPINAL INJURIES

PLEASE NOTE:

- **ALL REFERRAL INFORMATION MUST BE COMPLETED IN FULL. INCOMPLETE REFERRALS WILL BE RETURNED TO BE COMPLETED.**

A FEE MAY BE CHARGED TO PATIENTS WHO FAIL TO PROVIDE AT LEAST 24 HOURS NOTICE OF CANCELLATION FOR A SCHEDULED APPOINTMENT OR TEST.

PLEASE NOTE

ACKNOWLEDGEMENT OF REFERRAL

☐ **RECEIVED.** Please note the standard wait time for consultation is _____ *months* from the original referral date.
<u>The wait time can fluctuate each month</u>. Our office will notify the patient one month prior his/her appointment.

☐ **We require additional information for the above patient.** Please update and refax.
☐ Radiology report ☐ Medical Images (CD of x-ray or films)

☐ **This patient is not an appropriate candidate for our clinic.** Please re-direct the referral to: _____