



Orthopedic Assessment Clinic PRIMARY HIP AND KNEE ARTHROPLASTY REFERRAL FORM

FAX NUMBERS:

Aberdeen: 902-752-0765
Dartmouth General / QEII: 902-425-2725

Cape Breton Regional: 902-563-7855
Valley Regional: 902-678-8516

REFERRAL REQUEST

Select one of the three following options:

- Next available surgeon within specific zone (please select one area only):
 Aberdeen Cape Breton Regional Hospital Dartmouth General/QEII Valley Regional
- Specific surgeon: Dr. _____
- Self-Management only (Available in Cape Breton only; includes education and/or exercise)

REASON FOR REFERRAL - AFFECTED JOINTS

- Left Hip Right Hip Left Knee Right Knee

ADDITIONAL PATIENT INFORMATION:

Patient has evidence of arthritis on clinical exam and x-ray and reports arthritis symptoms are negatively impacting their quality of life. Yes No

Patient has failed adequate trial of non-surgical treatment management. Yes No

Have medical conditions that may preclude or delay surgery being investigated AND treated, e.g. cardiac, pulmonary, vascular or metabolic disease? Yes No

Other information i.e. medications, history, allergies, etc. (attach cumulative patient profile from EMR if possible):

REFERRAL SOURCE:

Name (please print): _____ CPSNS#: _____
 Signature: _____ Date: _____
 Phone: _____ YYYYY-MM-DD

FOR INTERNAL USE ONLY:

Date Referral Received: _____ YYYYY-MM-DD MRN#: _____

**Current X-ray (within 1 year) of referred joint must be available on the PACS system.
Incomplete Referrals including missing X-rays will be returned without being processed.**

Knee: AP weight bearing, AP/LAT with skyline patella; Hip: AP pelvis, AP/LAT affected side

