Orthopedic Assessment Clinic & Pre-Habilitation
PRE-HABILITATION/CONSERVATIVE MANAGEMENT REFERRAL

Exercise and education program for people with hip and/or knee arthritis involving an inter-professional team (may include OT, PT, SW, RN, and Dietitian)

❑ ***Central Zone:*** ***Fax: 902-425-2725***
❑ ***Eastern Zone:*** ***Fax: 902-563-7855***
❑ ***Western Zone:*** ***Fax: 902-678-3733***
❑ ***Northern Zone:*** ***Fax: 902-755-7558***

❑ **Non-Surgical:** Conservative Management Group Education and/or Exercise Program

❑ **Non-Surgical:** GLA:D™ Canada Program (Central Zone only)

❑ **Surgical:** Pre-Habilitation Group Exercise and Education Program

Surgeon: _____ Estimated surgery date (YYYY/MON/DD): _____

Planned surgical procedure (if applicable): ❑ **Hip arthroplasty** ❑ Left ❑ Right ❑ **Knee arthroplasty** ❑ Left ❑ Right ❑ Unicondylar

Previous hip or knee arthroplasty(s): ❑ Left hip ❑ Right hip ❑ Left knee ❑ Right knee

Dates of previous hip or knee arthroplasty(s): _____ (YYYY/MON/DD)

Previously enrolled in Pre-Habilitation: ❑ Yes ❑ No ❑ Unsure

Unstable medical condition (e.g. physical, cognitive) that would be a barrier to their meaningful participation in the program? ❑ Yes ❑ No If yes, describe: _____

Current Mobility Level (if known):
❑ Independent (no aides) ❑ Cane ❑ Crutches ❑ Walker ❑ Orthotic/Brace
Details/Other: _____

Current Living/Support Situation (if known):
❑ Alone ❑ Spouse/Partner ❑ Family ❑ Assisted living ❑ Private/Public home supports in place
Details/Other: _____

Occupation (if applicable): _____

Barriers to attending program (transportation, finances, supports etc.)? ❑ Yes ❑ No
If yes, describe: _____

Other Relevant Details (arthritic joint, functional impairments, etc.): _____

_____

_____

Referral Source (please print):

Name: _____ Contact Number: _____

❑ Initial Assessment/Consult attached Discipline: _____

Date (YYYY/MON/DD): _____

FOR Prehab Staff USE ONLY:

Staff: _____ Date Received: _____ (YYYY/MON/DD)