nova scotia health authority

Orthopedic Assessment Clinic
PRIMARY HIP AND KNEE ARTHROPLASTY REFERRAL FORM

FAX NUMBERS: **Aberdeen: 902-752-0765** **Cape Breton Regional: 902-563-7855**
Dartmouth General / QEII: 902-425-2725 **Valley Regional: 902:678-8516**

REFERRAL REQUEST

Select one of the three following options:

1. ❑ Next available surgeon within specific zone (please select one area only):
   ❑ Aberdeen ❑ Cape Breton Regional Hospital ❑ Dartmouth General/QEII ❑ Valley Regional
2. ❑ Specific surgeon: Dr. _____
3. ❑ 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:** _____ YYYY–MM–DD

Phone: _____

FOR INTERNAL USE ONLY:

Date Referral Received: _____ YYYY–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