Request for Orthopaedic Consultation

Hip and Knee Arthritis Program

FAX: (855) 526-5322 PHONE: (519) 685-8500 x37873

South West Musculoskeletal Rapid Access Clinic

☐ **Routine** ☐ **Urgent – rationale:**

X-RAY REPORTS WITHIN 6 MONTHS MUST ACCOMPANY REFERRAL. MRI is NOT recommended.

Knee: Bilateral knee standing AP & tunnel, lateral knee at 30°, skyline **Hip:** AP pelvis, AP and lateral hip

PLEASE INCLUDE CPP (Cumulative Patient Profile) and indicate if any of the following apply:

☐ ICD ☐ Pacemaker ☐ Dialysis ☐ Blood product refusal ☐ A1c _____

Referring Physician Information

Name: _____
Specialty: _____
Address: _____
City/PC: _____
Phone: _____
Fax: _____
Email: _____
Billing #: _____

Signature: _____
PCP (if different): _____

Patient Information

Name: _____
Address: _____
City/PC: _____
Date of Birth: _____
Health Card #: _____ VC: _____
WSIB Claim #: _____
Gender: ☐ Male ☐ Female ☐_____
☐ Interpreter, language: _____
Primary Phone: _____
Alternate Phone: _____
Email: _____

SURGICAL CONSULTATION: ❒ First available (shortest total wait time) OR Select preference:

☐ **LONDON HEALTH SCIENCES CENTRE (UH)**
- ☐ Dr. A Chen
- ☐ Dr. J. Howard
- ☐ Dr. B. Lanting
- ☐ Dr. S. MacDonald
- ☐ Dr. D. Naudie
- ☐ Dr. E. Schemitsch
- ☐ Dr. E. Vasarhelyi

☐ **WOODSTOCK HOSPITAL**
- ☐ Dr. A. Bigham (hip only)
- ☐ Dr. S. Petis
- ☐ Dr. G. Xenoyannis

☐ **STRATHROY GENERAL HOSPITAL**
- ☐ Dr. R. Rajgopal (knee only)
- ☐ Dr. V. Rajgopal

☐ **BRIGHTSHORES HEALTH SYSTEM**
- ☐ Dr. J. Adlington
- ☐ Dr. G. Costa
- ☐ Dr. E. Haider (knee only)
- ☐ Dr. S. Manwell

☐ **ST. THOMAS ELGIN GENERAL HOSPITAL**
- ❒ Dr. S. Alfayez (knee only)
- ❒ Dr. A. Van Houwelingen

☐ **STRATFORD GENERAL HOSPITAL**
- ☐ Dr. H. Asham
- ☐ Dr. J. Guy
- ☐ Dr. S. St George
- ☐ Dr. K. Vannitamby

☐ **TILLSONBURG DISTRICT MEMORIAL HOSPITAL**
- ❒ DR. C. Inculet

REASON FOR REFERRAL ☐ Primary Replacement ☐ Opinion/management advice

☐ Right Hip ☐ Left Hip ☐ Moderate to severe OA ☐ Mild OA, not responding to treatment

☐ Right Knee ☐ Left Knee ☐ Other:

*****PLEASE SEND REVISION REFERRALS DIRECTLY TO SURGEON*****

Patient has seen/ is referred to another specialist for this issue? (attach consult) ☐ YES ☐ NO

Has patient had a HIP OR KNEE joint replacement previously? ☐ YES (include Date/Surgeon or site) ☐ NO

Notes:

Please note: Patients may be asked about their interest in participating in relevant research studies V.1908/26