Orthopedic Assessment Clinic (OAC)
PRIMARY HIP AND KNEE ARTHRITIS/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 following options: *(For wait-time information please visit:* ***https://waittimes.novascotia.ca/****)*

1. **Arthritis Self-Management Program** (includes education and/or exercise): _____
2. **Intake Assessment and Surgical Consultation** *(if indicated)*. Please select one area only:
   - ❑ NZ - Aberdeen ❑ EZ - CB Regional ❑ CZ - Dartmouth General/Halifax Infirmary ❑ WZ - Valley Regional
   - ❑ Next available* surgeon (*Consult wait-time plus surgical wait-time)
   - ❑ Request Specific Surgeon: _____

***Note:** Referrals related to WCB claims should be directed to the Centralized Surgical Services Program:
http://www.wcb.ns.ca/Portals/wcb/V2.6_CSSP%20Referral%20Form.pdf

REASON FOR REFERRAL - AFFECTED JOINT(S)

❑ Left Hip ❑ Right Hip ❑ Left Knee ❑ Right Knee

Comments: _____

CLINICAL 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

Duration of symptoms: ❑ 0-6 months ❑ 6-12 months ❑ 12 months and up

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

Using medication for arthritis pain control? ❑ Yes ❑ No - Details: _____

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

Current gait aids: ❑ None ❑ Cane ❑ Walker ❑ Wheelchair

Functional Limitations (ADL, IADLs): ❑ None ❑ Mild ❑ Moderate ❑ Severe

Is the patient unable to work because of impairments of their affected joint: ❑ Yes ❑ No

Has the affected joint contributed to the patient falling in the past 12 months: ❑ Yes ❑ No

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

_____

_____

REFERRAL SOURCE

Name: _____ (Print) **CPSNS#:** _____ **Date:** _____ (YYYY/MON/DD)

Signature: _____ **Phone:** _____ **Fax:** _____

FOR INTERNAL USE ONLY

Date Referral Received (YYYY/MON/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