Orthopedic Central Intake
Patient Referral Form

Incomplete Requisitions will be Returned

Patient Label

Referral Date				Physicians Information (use stamp when applicable)
Patient Information				
Name: _____ Address: _____ Date of Birth: _____ Health Care #: _____ Phone Home: _____ Phone Alt: _____				Physicians Signature:
Schedule Patient For Next Available Surgeon	□ YES □ NO and Surgeon Requested _____			
Diagnosis	□ Osteoarthritis □ Traumatic Arthritis □ Rheumatoid Arthritis □ Avascular Necrosis □ Fracture □ Joint derangement NYD □ Failed Replacement □ Other_____			

Primary Affected Joint (s) √	Right	Left	Bilateral	Reason for Referral
Hip				□ Arthroplasty □ Injection □Other:_____
Knee				

Please have x-rays of affected area completed no greater than 6 months prior to the referral

KNEE: 1. AP weight bearing both knees
2. Lateral of the knee
3. Skyline

HIP: 1. AP pelvis centered to pubis
2. Lateral of proximal half of affected femur

Symptoms	Treatments
□ Pain with activity □Mild □Moderate □Severe □ Pain at rest/night □Mild □Moderate □Severe □ Groin Pain □ Joint Swelling □ Instability □ Locking □ Other_____	□ None □ Previous Orthopedic Surgery □ Analgesics/Narcotics □ NSAIDS □ Physiotherapy □ Bracing □ Arthroscopy □ Other _____ □ Joint injections: Trials_____ Last Injection_____ Effectiveness □None □1-4 mos □ > 4 mos
Duration of Symptoms	**Mobility Aids**
□ 3-6 months □ 6-12 months □ >1 year Other:_____	□ Walking Aids □ Wheelchair Other:_____

Health History			
□ None If yes √ all that apply	□ Cardiovascular Disease □ GI Disease □ Cancer	□ Respiratory Disease □ Renal Disease □ Diabetes	□ Neuro Disorders □ Mental Disorders □ Other

For Orthopedic Intake Clinic Use Only

OCI Screening	Triage Outcomes	OCI Notes
Received:_____ DI: _____ □ Complete □ Incomplete Date Returned: _____ Date Complete:_____	Priority: □ P1 □ P2 □ P3 □ P4 □ Not Appropriate Triage Date:_____ Comments:_____ _____	_____ _____ _____ _____ _____

Forward to: *Orthopedic Central Intake Clinic*
Western Memorial Regional Hospital 1 Brookfield Ave, Corner Brook, NL, A2H 6J7
Ph: (709) 637-5000 ext: 6744 Fax: (709) 637-5262