



Orthopedic Central Intake Patient Referral Form

Incomplete Requisitions will be Returned

Patient Label

Physician Instructions Orthopedic Central Intake Patient Referral Form

*Please note all sections of the referral must be completed for processing
FAX Referral to: 637-5262*

To request a **routine** orthopedic referral for patients who are possible knee and/or hip joint replacement candidates, please complete the first page of this form. Send the referral by fax to 637-5262.

The form will be available in PDF format on the Western Health website.

and

On the **intranet**

Patients have the option of being scheduled for an appointment with the next available surgeon or the surgeon of their choice. Please note there may be a longer waiting time for surgeon of choice.

To ensure timely processing of your request, include the following documents:

1. For ALL patients: Recent list of prescribed medications, this can be accessed through the patients' pharmacy.
2. For **All Total Joint Replacement**: Recent X-Ray views (less than 6 months) are required:
 - **KNEE:**
 1. **AP weight-bearing both knees**
 2. **Lateral of knee**
 3. **Skyline**
 - **HIP:**
 1. **AP pelvis centered to pubis**
 2. **Lateral of proximal half of affected femur**

You will receive confirmation of receipt of your referral within 2 business days. You and your patient will be contacted to confirm an appointment time.

For more information or to request more referral forms call:
637-5000 ext 6744

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