Burnaby Hospital Hip & Knee Arthroplasty Centre Referral

Patient Name **M F DOB**

Care Card #

Address

Patient Phone Home	**Cell**	**Work**	**Speaks:** ☐ English ☐ Other:
Referring Practitioner Name:		**Phone:**	**FAX**

COMPLETE ALL RELEVANT FIELDS. ATTACH MEDICAL HISTORY/ MEDICATION LIST.
FAX TO 604-419-1418
INCOMPLETE REFERRAL WILL NOT BE PROCESSED.

Reason for referral:	☐ Re-referral
☐ First available surgeon (recommended). Or ☐ Specify surgeon:_____	
Affected joint (s): Knee: ☐ Right ☐ Left ☐ Bilateral **Hip:** ☐ Right ☐ Left ☐ Bilateral	
Attach X-rays as specified of the affected joint (s) (done within 3 months) *	
☐ Knee: 1. **Weight bearing** AP of both knees 2. Lateral knee of affected side 3. Skyline of affected side 4. Notch	
☐ Hip: 1. AP Pelvis including proximal 1/3 of femurs 2. True lateral of affected hip	
Pain with walking: ☐ None/Mild ☐ Moderate ☐ Severe	**Loss of flexion, extension or joint stability** ☐ None/Mild ☐ Moderate ☐ Severe
Walking tolerance <u>without</u> significant pain: ☐ Over 5 blocks ☐ 1 to 5 blocks ☐ Less than 1 block ☐ Household	**Mobility aids used:** ☐ Cane ☐ Crutches ☐ Walker ☐wheel chair.
☐ **Pain at rest (sitting, lying down, sleeping).** How many nights a week is sleep disturbed? _____	**Treatments Trialled** ☐ Physio therapy ☐ Specialized exercise ☐ Joint injections. Other:
	Analgesics: ☐ PRN Opioids ☐ Scheduled Opioids

BMI _____ **Medical concerns** ☐ None ☐ Mild or past significant problem
☐ Constant significant, difficult to control. **Mental health:** ☐ Active Depression ☐ **Other comments**:

Signature. Referring Practitioner_____ Date: DD/MM/YY _____

For Burnaby Hip/Knee Centre USE ONLY

☐ * **Requires urgent** surgeon consult:

	Date	Time	Initials
☐ Received referral from Referring Practitioner (RP)			
☐ Surgeon appointment date _____Patient notified.			
☐ If surgeon specified, patient & RP notified of this consult date & first available date			
☐ Not a surgical candidate. Care plan to patient. Letter/Care plan to RP			