Ridge Meadows Hospital
Hip & Knee Replacement
Clinic Referral

fraserhealth

Patient Name _____

PHN _____

Date of Birth _____ M / F

Address _____

Phone _____

Referring Practitioner Name: **Phone:** **Fax:**

PLEASE ATTACH MEDICAL HISTORY/ MEDICATION LIST
FAX TO 604-476-7840

Reason for 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) (within 3 months) - <u>MUST BE DONE AT A FHA HOSPITAL</u>

- ☐ Knee: 1. **Weight bearing** AP of both knees 2. Lateral knee of affected side 3. Skyline of affected side 4. Notch
- ☐ Hip: 1. Standing AP Pelvis including proximal 1/3 of femurs 2. True lateral of affected hip

Height _____ **Weight** _____ **BMI** _____

Diabetic ☐ **HbA1C:** (within 3 months) _____

Mental health: ☐ Cognitive Impairment ☐ Mental Health Condition(s) _____

Substance Use: ☐ Regular Alcohol Use ☐ Recreational Drug Use ☐ Smoker

Medical concerns: ☐ None ☐ Mild or past significant problem ☐ Constant, significant, difficult to control

Other comments: _____

_____

Signature, Referring Practitioner _____ **Date:** dd/mm/yy _____

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
- ☐ Wheelchair

Analgesics:
- ☐ PRN/Scheduled Opioids
- ☐ Anti-inflammatories
- ☐ PRN Tylenol/Advil

Pain at rest:
- ☐ Sitting
- ☐ Lying down
- ☐ Sleeping

How many nights a week is sleep disturbed? _____

Treatments Trialled
- ☐ Physiotherapy
- ☐ Specialized exercise
- ☐ Joint injections: Date _____
- ☐ Other:

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