Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

Lower Extremity Non-Arthroplasty Hip and Knee Consultation Request Form

Instructions:
To facilitate prompt and appropriate assessment/consultation of your patient by an orthopaedic surgeon, please:

1. Complete this form and provide all requested information.
2. **Sign** and **Date** the bottom of the second page.
3. Fax form and radiology report to appropriate fax number (see attached directory).

NB: CONTACT SURGEON DIRECTLY IF THIS IS AN EMERGENCY

COMPLETING THIS FORM DOES NOT GUARANTEE ACCEPTANCE OF THIS PATIENT

Consult directed to:

◯ Next available surgeon ◯ Specific Surgeon: _____

Referral Type:

☐ New ☐ Repeat ☐ WCB ☐ WCB Appeal ☐ MPIC ☐ Medical Legal ☐ 2nd Opinion

Patient Demographics (Please print clearly. Use label if available): ◯ Female ◯ Male

Last Name: _____ First Name: _____

DOB: ☐☐☐☐ / ☐☐ / ☐☐ (Y Y Y Y / M M / D D) MHSC: _____ PHIN: _____

Tel: (Home) _____ (Work) _____ (Other) _____

Address (Include postal code) _____

Does patient read and speak English? ◯ Yes ◯ No

Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

Radiology: A copy of a plain x-ray report of the relevant joint(s) is required for us to assess this request. AP knee films should be done standing. MRI is necessary for knees without advanced arthritis and shoulders.

☐ Plain x-ray Date _____ Location _____

☐ Other: _____ Date _____ Location _____

☐ _____ Date _____ Location _____

Reason for Referral:

☐ Hip Problem ◯ Right ◯ Left ◯ Bilateral

Diagnosis: ☐ Osteoarthritis: ☐ Post Traumatic ☐ Degenerative

☐ Labral Tear (need MRI)

☐ AVN

☐ Knee Problem ◯ Right ◯ Left ◯ Bilateral

Diagnosis: ☐ Meniscal Tear ☐ Locked Knee

☐ ACL Tear ☐ Acute ☐ Chronic

☐ Patellofemoral Instability ☐ Patellofemoral Pain

☐ Osteoarthritis: ☐ Mild ☐ Moderate ☐ Severe

☐ OCD

Other _____

Symptom Duration: ◯ < 2 weeks ◯ 2-6 weeks ◯ 6-12 weeks ◯ 3-6 months ◯ < 6-12 months ◯ 12-24 months ◯ >24 months

VAS Pain Score (patient rated):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Minimal pain Worst pain ever

Athletic Level: ◯ None ◯ Recreational ◯ Highly Competitive ◯ Professional

Non-operative Management Attempted:

	Effective	Partially effective	Not appropriate for me	Unable	Don't want to try	Not attempted
Physio or Other Therapy	◯	◯	◯	◯	◯	◯
NSAID	◯	◯	◯	◯	◯	◯
Joint Injection (location_____)	◯	◯	◯	◯	◯	◯
Bracing	◯	◯	◯	◯	◯	◯
Orthotics	◯	◯	◯	◯	◯	◯

Is this patient wishing to pursue surgery? ◯ Yes ◯ No ◯ Patient Uncertain

History / Medications / Allergies / Social (attach separately if preferred): _____

_____

_____

Signature of referring physician: _____ **Date:** _____