Alberta Health Services

Affix patient label within this box

Hip and Knee Replacement Referral

Please print, complete and return this form by fax to the appropriate clinic below. Attach the following with the completed form

- Relevant medical history/EMR Record
- X-ray report - **MRI is not required for this referral** ☐ X-ray reports attached
  Knee: AP weight bearing, lateral of knee with knee flexed, Skyline
  Hip: AP pelvis centered at pubis, AP and lateral of proximal half of affected femur

Patients must be on appropriate non-surgical treatment prior to evaluation *(e.g. medication, physiotherapy, walking aids, shoe inserts).*

Select One

Calgary
Fax - 403.221.4387
Phone - 403.265.5228

Camrose
Fax - 780.679.2630
Phone - 780.672.2420

Edmonton
Fax - 780.432.6395
Phone - 780.433.3155

Grande Prairie
Fax - 780.402.9829
Phone - 780.402.7181

Lethbridge
Fax - 403.942.0186
Phone - 403.942.0182

Medicine Hat
Fax - 403.528.8163
Phone - 403.502.8648 ext 1530

Red Deer
Fax - 403.358.5808
Phone - 403.309.2001

Westlock
Fax - 780.349.6686
Phone - 780.349.6601

Bonnyville
Fax - 780.826.6531
Phone - 780.826.8255

Reason for Referral

What is the primary reason you are referring this patient?

_____

_____

Primary Affected Joint(s) ✔	Right	Left	Bilateral
Hip			
Knee			

Type of Problem
☐ Primary
☐ Revision

Duration of Symptoms
☐ 3 - 6 months ☐ 6 - 12 months
☐ Years ☐ Other *(specify)* _____

Is this a WCB claim?
☐ No
☐ Yes, specify claim number _____

Will you be assigning the patient to the next available surgeon?
☐ No, specify surgeon name *(last, first)* _____
☐ Yes

Height _____ cm | Weight _____ kg | BMI _____

Previous Orthopaedic Surgeries

Has the patient undergone any previous orthopaedic surgeries?
☐ No
☐ Yes, complete ►

Surgery	Surgeon	Year

Is the patient currently controlling joint pain with medication?
☐ No ☐ Yes, complete ►

☐ Narcotics ☐ Over the counter ☐ NSAID/COXIB
☐ Other *(specify)* _____

Comments

Alberta Health Services

Hip and Knee Replacement Referral

Check appropriate boxes	None	Mild	Moderate	Severe
Pain on motion *(e.g. walking, bending)*				
Pain at rest *(e.g. while sitting, lying down, or causing sleep disturbance)*				
Other functional limitations *(e.g. putting on shoes, managing stairs, sitting to standing, sexual activity, bathing, cooking, recreation or hobbies)*				
Abnormal findings on physical exam related to most severely affected joint *(e.g. deformity, instability, leg length difference, restriction of range of motion on exam)*				

Highest level of walking supports *(for the affected joint that patient currently uses to carry out usual activities e.g. work, leisure)*

☐ None/Orthotics ☐ Brace/Cane ☐ Crutches/Walker ☐ Wheelchair

Highest level of medication to manage affected joint

☐ PRN pain medication

☐ Regularly-scheduled medication use

☐ Maximum medical therapy appropriate for patient

Ability to walk without significant pain

☐ Over 5 blocks ☐ 1-5 blocks ☐ Less than 1 block ☐ Household ambulator

Threat to patient role and independence in society *(i.e. ability to work, give care to dependents, live independently*)
Must relate to affected joint

☐ Not threatened but more difficult

☐ Threatened but not immediately

☐ Immediately threatened or unable

Rate the level of medical complexity of the patient *(based on number and/or severity of key comorbid conditions, excluding hip/knee condition)*

☐ No medical problems

☐ Current mild medical problems or past significant medical problems

☐ Moderate medical disability or morbidity/requires “first line” therapy

☐ Severe/constant significant disability/“uncontrollable” constant medical problems

☐ Extremely severe/immediate treatment required/end organ failure/severe impairment of function

Referring Clinician Information *(complete or use practice stamp below)*		
Name	PRACID	Practice Stamp *(if applicable)*
Address		
Phone	Fax	
Signature	Date *(yyyy-Mon-dd)*	