North Simcoe Muskoka Arthroplasty Intake Clinic

Phone (705) 735-0239
Toll Free Fax 1-(866) 449-0994 – Referrals Only
Fax (705) 792-3329 – Referrals Only

Royal Victoria Regional Health Centre

Collingwood General & Marine Hospital

Orillia Soldiers' Memorial Hospital

REFERRAL FORM Date:

PATIENT INFORMATION:	REFERRING PHYSICIAN:
Patient Name:_____	Physician Name:_____
DOB (dd/mm/yyyy):_____Sex: □ M □ F	Address:_____
Address: _____	City: _____Postal Code:_____
City: _____Postal Code:_____	Phone: _____
Phone: _____	Fax: _____
HCN:_____	Physician Billing #: _____
WSIB #:_____	**Signature:**_____

LOCATION/SURGEON:

Preferred Clinic Location: □ Barrie □ Collingwood □ Orillia

Assign to next available Surgeon: □ Yes □ No Preferred Surgeon: _____

REASON FOR REFERRAL:

Diagnosis:_____

Affected Joint(s):

Hip: □ Right □ Left □ Bilateral
Knee: □ Right □ Left □ Bilateral
Shoulder: □ Right □ Left □ Bilateral
Other:_____

X-ray report must be attached

□ Hip: AP pelvis/AP hip/ cross table lateral of affected hip
□ Knee: AP or PA standing/ lateral/ skyline
□ Shoulder: AP/ lateral/ axillary/ outlet

Please attach any other relevant imaging

TREATMENTS TO DATE (check all that apply):

□ Acetaminophen	□ Steroid Injections	□ Physiotherapy	□ Braces
□ NSAID/COXIB	□ Viscosupplementation	□ Exercise	□ Walking Aids
□ Narcotics	□ Arthroscopy	□ Weight Loss	□ Other:

MEDICATIONS AND MEDICAL HISTORY:

Please list or attach relevant medical history (medications, co-morbidities, allergies, surgeries…)

□ see attached cumulative patient profile

Arthroplasty Intake Clinic use only: Date Received: Appointment:
Reviewed : _____ □ New
□ APP □ Surgeon V#: _____
□ Other: _____ OP#: _____