**RAPID ACCESS CLINIC – NEJAC REFERRAL FORM**

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| **REFERRAL DATE:** Click here to enter text. |
| **Please fax the completed referral to CENTRAL INTAKE** |
|  | **Fax:** | **1-855-567-7969** | **Phone :** | **1-855-653-7966** |
| **ASSESSMENT**: | Your patient will be assessed at the NEJAC closest to their home. |  |
| **CONSULT**: | When your patient has been determined to be a Surgical candidate they will be given the option to select a **specific surgeon** or the **Next available surgeon** (specific site or NELHIN).Surgeon Preference (if appropriate): |
| **PATIENT INFORMATION (sticker)** | **REFERRING PHYSICIAN INFORMATION (sticker)** |
| Name: Click here to enter text. | Name: Click here to enter text. |
| Address: Click here to enter text. | Address: Click here to enter text. |
| City, Postal code: Click here to enter text. | Phone: Click here to enter text. Fax: Click here to enter text. |
| DOB**:** DD MM YYYY: Click here to enter text. | Specialty: Click here to enter text. |
| Gender: [ ]  Male [ ]  Female | OHIP Billing Number: Click here to enter text. |
| Health Card Number: Click here to enter text. | **Family Physician Information** (if different from above)Name: Click here to enter text. |
| Phone: Click here to enter text.Alternate Phone/Contact: Click here to enter text. |
| **CLINICAL INFORMATION** |
| **Joint(s):** HIP [ ] Left [ ]  Right [ ]  Bilateral KNEE [ ] Left [ ]  Right [ ]  Bilateral SHOULDER [ ] Left [ ]  Right [ ]  Bilateral | **Diagnosis:** [ ] Osteoarthritis [ ]  Painful TKR/THR [ ] Inflammatory Arthritis [ ]  Frozen Shoulder [ ] Impingement syndrome [ ]  Instability Rotator cuff tear: [ ] Partial thickness [ ] Full thickness [ ] OTHER: Click here to enter text. |
| **Level of Pain:** [ ]  Mild [ ]  Moderate [ ]  Severe |
| **Functional Limitation:** [ ]  Mild [ ]  Moderate [ ]  Severe |
| **DIAGNOSTIC IMAGING REQUIREMENTS** |
| **ATTACHED:** [ ]  Yes [ ]  Pending**Knee**: Bilateral Weight Bearing AP at 0° & 30° flexion, lateral and skyline of affected knee(s)**Hip**: AP pelvis, AP & lateral of affected hip(s)**Previous THR**: above views + AP of proximal half of femur (ensure stem is visible)**Shoulders** A/P in neutral, Transcapular, Axillary and Outlet* X-Ray within **last 6 months,**
* US or MRI for shoulders only
* MRI is **NOT** recommended for initial screening of OA
 |
| **Is this condition covered under WSIB?** [ ]  Yes [ ]  No |
| **CURRENT MEDICATIONS LIST** |
| **ATTACHED:** [ ]  Yes [ ]  No |
| **NOTE**: If not attached please inform patient to bring list to first NEJAC appointment. |
| **ADDITIONAL IMAGING / PHYSIOTHERAPY NEEDS:** |
| **I am referring this patient to the Rapid Access Clinic (NEJAC) and authorize:** [ ] Yes [ ]  No Transfer of authority to order and follow up on additional x-ray imaging for my patient to an AdvancedPractice Physiotherapist as they deem clinically appropriate[ ] Yes [ ]  No Use of this referral to refer my patient to outpatient physiotherapy services as deemed clinically appropriate |
| **PCP Signature:**  | Click here to enter text. |  | **Date:** Click here to enter text. |  |

“This referral form has been adapted for the NELHIN with permission from Sunnybrook Holland Orthopaedic & Arthritic Centre 2010”

REV August 2019 NEJAC – REFERRAL FORM