**RAPID ACCESS CLINIC – NEJAC REFERRAL FORM**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 Advanced  Practice 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