NEJAC | CÉANE
NORTH EAST JOINT ASSESSMENT CENTRE | CENTRE D'ÉVALUATION DES ARTICULATIONS DU NORD-EST

RAPID ACCESS CLINIC – NEJAC REFERRAL FORM

Ontario

REFERRAL DATE: DD MM YYYY

Please fax the completed referral to CENTRAL INTAKE

Fax: 855-567-7969 **Phone : 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:	Name:
Address:	Address:
City, Postal code:	Phone: Fax:
DOB: DD MM YYYY:	Specialty:
Gender: ❒ Male ❒ Female	OHIP Billing Number:
Health Card Number:	**Family Physician Information** (if different from above)
Phone:	Name:
Alternate Phone/Contact:	

CLINICAL INFORMATION

Joint(s): HIP ❒ Left ❒ Right ❒ Bilateral
KNEE ❒ Left ❒ Right ❒ Bilateral
SHOULDER ❒ Left ❒ Right ❒ Bilateral

Level of Pain: ❒ Mild ❒ Moderate ❒ Severe

Functional Limitation: ❒ Mild ❒ Moderate ❒ Severe

Diagnosis:

- ❒ Osteoarthritis
- ❒ Revision (Hip/Knee)
- ❒ Inflammatory Arthritis
- ❒ Frozen Shoulder
- ❒ Impingement syndrome
- ❒ Instability

Rotator cuff tear:

- ❒ Partial thickness
- ❒ Full thickness

❒ OTHER:

Is this condition covered under WSIB? ❒ Yes ❒ No

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

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: **Date:**

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