FAX PATIENT REFERRAL TO: **REFERRAL MANAGEMENT SERVICES**
FAX: 1-855-355-1921
PH: 1-833-337-7770

PROVINCIAL - Hip & Knee Arthroplasty

This referral form is for patients who may require hip or knee joint replacement or revision surgery. Emergent referrals should follow standard process through SFCC. For **ALL** other orthopedic consultation and surgery, please contact a specialist directly.

PATIENT INFORMATION:	Last Name:		First Name:	
Date of Birth:	Age:	Address:		
City:		Prov:	PC:	HSN:
Primary phone:		Alternate Phone:		

REFERRING PRACTITIONER & CLINIC INFORMATION:			**PATIENT AWARENESS:**	
☐ Family Doctor ☐ Nurse Practitioner ☐ Specialist ☐ Other (Specify)_____	Name: Address: Phone: Fax:		Is the Patient aware of this referral? Is the Patient interested in surgery? Is the Patient aware of pooling options?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

REFERRAL TO:

Step One: Choose location(s)			**Step Two:** Choose Next Available or choose a Specific Surgeon	**Step Three:** Is this a revision?
☐ **NORTH**	☐ Saskatoon ☐ Prince Albert ☐ Lloydminster	If **no location(s) selected**, patient will receive surgeon in or closest to home location.	☐ Next Available Surgeon ☐ Specific Surgeon Dr: _____ *Note: Selecting a specific surgeon may increase patients wait time for surgery* Are there surgeons the patient does not want to see? If **yes**, specify: Dr. _____	☐ Yes ☐ No Original Surgeon (if known): Dr: _____
☐ **SOUTH**	☐ Regina ☐ Moose Jaw			

REASON FOR REFERRAL:

☐ Hip Arthritis	☐ Right ☐ Left	**Required X-ray views**: AP Pelvis/Standing, Lateral Hip	
☐ Knee Arthritis	☐ Right ☐ Left	**Required X-ray views**: AP Standing/Lateral and Skyline of Knee	
Are there medical conditions that may preclude or delay surgery?	☐ Yes ☐ No	If yes, please explain below.	

Describe orthopedic complaint: For triage purposes, if space is too limited on the form, attach supporting information.

MEDICAL INFORMATION:

Height:		☐ ft ☐ in ☐ cm	**Weight:**		☐ lbs ☐ kgs	**Smoker:**	☐ Yes ☐ No

NON-OPERATIVE MANAGEMENT ATTEMPTED:

☐ Weight Loss	☐ Tylenol	☐ Exercise/Physio	☐ GLAD program
☐ Brace	☐ Anti-inflammatories	☐ Joint Injections	☐ Other (specify):_____

REQUIRED ATTACHMENTS: (Note: Referrals missing these attachments will be returned to referring provider)

- A summary of the patient's health history and medication list
- X-ray reports(not MRI) completed within 6 months by joint
- Relevant subspecialist consults, if available

Referring Physician Name (print) and Signature:	Date:

POOLED REFERRAL INFORMATION: Patients offered the pooled referral option will be contacted by the surgeon who can perform the procedure soonest (including combined wait to consult and wait to surgery). This service shares de-identified referral information with all the specialists in this group to aid in reducing patient wait times and improve the patient experience.

Receiving Specialist/RMS Use Only:

Redirecting Specialist: ☐ Pooled ☐ Specific Dr._____	Date: