

Musculoskeletal Central Intake

North Simcoe Muskoka

Hip & Knee Arthritis

Phone (705) 735-0239

Toll Free Fax (866) 449-0994 – Referrals Only

Fax (705) 792-3329 – Referrals Only

REFERRAL DATE: (YYYY/MM/DD)	
REFERRING PHYSICIAN:	
Physician Name: _____	
Address: _____	
City: _____ Postal Code: _____	
Phone: _____	
Fax: _____	
Physician Billing #: _____	
Signature: _____	
PATIENT INFORMATION:	
Patient Name: _____	
DOB: (YYYY/MM/DD) Gender: _____	
Address: _____	
City: _____ Postal Code: _____	
Phone: _____	
HCN: _____	
WSIB #: _____	
CONSULT OPTIONS:	
<input type="checkbox"/> Next available assessment within North Simcoe Muskoka LHIN <u>or</u>	
<input type="checkbox"/> Preferred Clinic Location:	
<input type="checkbox"/> Collingwood General and Marine Hospital	
<input type="checkbox"/> Orillia Soldiers' Memorial Hospital	
<input type="checkbox"/> Royal Victoria Regional Health Centre	
<input type="checkbox"/> Preferred Surgeon: _____	
REASON FOR REFERRAL:	
Moderate to severe arthritis	
Knee: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	
Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	
IMAGING INSTRUCTIONS:	
X-ray report of the affected joint must be attached	
If no x-ray is available from within 6 months, we recommend the following views:	
Knee: AP standing / lateral / skyline / tunnel (30° flexion in standing)	
Hip: AP Hip / AP Pelvis / Cross table lateral of affected hip	
Patients are required to bring their x-ray disc with them to their appointment.	
Please attach any other relevant imaging.	
In the setting of osteoarthritis, MRI is not usually further contributory.	
TREATMENTS TO DATE: (check all that apply)	
<input type="checkbox"/> Acetaminophen <input type="checkbox"/> Steroid Injections <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Walking Aids	
<input type="checkbox"/> NSAID/COXIB <input type="checkbox"/> Viscosupplementation <input type="checkbox"/> Exercise <input type="checkbox"/> Braces	
<input type="checkbox"/> Opioids <input type="checkbox"/> Weight Loss <input type="checkbox"/> GLA:D Canada <input type="checkbox"/> Smoking Cessation	
MEDICATIONS AND MEDICAL HISTORY:	
Please attach relevant medical history or cumulative patient profile (medications, co-morbidities, allergies, surgeries, etc.)	
Clinic use only:	
Received: _____	
Reviewed: _____	

