WATERLOO WELLINGTON Coordinated Access

**Waterloo Wellington Orthopedic Referral Form**
**Regional Coordination Centre Local Fax Number: 519-621-8688**
**Toll-Free Fax Number: 1-844-237-5240**
**Telephone Number: 519-947-1000**

| | | |
|---|---|---|
| Last Name: | First Name: | Gender: ☐ Male ☐ Female ☐ X _____ |
| DOB: | Phone (Primary): | Phone (Other): |
| Address: | City: | Postal Code: |
| Health Card #: | ☐ Social Barriers: | Language Barrier: ☐ YES ☐ NO |
| Height: Weight: | ☐ Identifies as First Nations, Inuit, Metis | Language Spoken: |
| Primary Care Provider: | | Allergies: ☐ NKA |

| | | | |
|---|---|---|---|
| **Schedule Patient for:** | ☐ No Preference | ☐ Preferred Surgeon: | ☐ Preferred City: |
| **Referral Priority:** | ☐ URGENT | ☐ Routine | ☐ 2nd Opinion |

**Reason for Referral:**

***Note: for emergency referrals, please contact the on call surgeon***

**Other Clinical Information** (History, Progress Notes and Medication List): ☐ Attached

**Primary Problem/Area:** ☐ **Required Imaging Reports Attached**

| | | | |
|---|---|---|---|
| ☐ Ankle ☐ R ☐ L | ☐ Foot ☐ R ☐ L | ☐ Hip ☐ R ☐ L | ☐ Shoulder ☐ R ☐ L |
| ☐ Arm ☐ R ☐ L | ☐ Forearm-Radius ☐ R ☐ L | ☐ Knee ☐ R ☐ L | ☐ Tibia ☐ R ☐ L |
| ☐ Elbow ☐ R ☐ L | ☐ Forearm-Ulna ☐ R ☐ L | ☐ Knee Arthroscopy ☐ R ☐ L | ☐ Wrist ☐ R ☐ L |
| ☐ Femur ☐ R ☐ L | ☐ Hand ☐ R ☐ L | ☐ Pelvis | ☐ Spine: |
| ☐ **OAC Clinic** (for moderate to severe OA of hip or knee)<br>If indicated based on OAC assessment, please refer on for: ☐ Injection ☐ Physiotherapy ☐ Bracing | | | ☐ Other: |

**Symptoms:**

☐ Pain on movement
Pain Level: ☐ Mild ☐ Moderate ☐ Severe
☐ Pain at rest
Pain Level: ☐ Mild ☐ Moderate ☐ Severe
☐ ROM Restrictions
☐ Difficulty sleeping
☐ Neurological deficit
☐ Joint swelling
☐ Other:

**Duration of Symptoms:**

☐ Acute onset
☐ 3-6 months
☐ 6-12 months
☐ Greater than 12 months
☐ Other:
☐ Started with injury
☐ **WSIB#:**

**Treatments to Date:**

☐ Bracing/Splinting
☐ Joint Injections
☐ Analgesics/NSAIDs
☐ Physiotherapy
☐ Weight Management
☐ Other:

**Mobility Concerns:**

☐ Cane
☐ Crutches
☐ Walker
☐ Wheelchair
☐ Falls Risk
☐ Other:

**Health History (Complete or attach CPP):**

☐ Hypertension ☐ CVD ☐ Cancer
☐ Cognitive Impairment ☐ Respiratory Disease ☐ Sleep Apnea
☐ Renal Disease ☐ CVA/Neurological ☐ Obesity

☐ Arthritis: ☐ Osteoarthritis ☐ Psoriatic ☐ Rheumatoid
☐ Diabetes: ☐ Insulin
☐ Other:

**Referring Provider Information**

Name:
Address:

Phone: Fax:
Billing Number: Date:

Signature:

**FOR INTERNAL USE ONLY**

Orthopedic Specialist:

**FOR MEDICAL SPECIALIST OFFICE STAFF USE ONLY**

Assessment/Triage Clinic Appt. Date:
Orthopedic Consultation Date:
Priority: ☐ 7days ☐ 30days ☐ 90days ☐ 182days
☐ Non-Surgical Candidate
☐ Incomplete Referral
Reason: