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:	☐ Aboriginal Status	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)
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: