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) 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: