REQUEST FOR ORTHOPAEDIC CONSULTATION

Referral Date: YYYY MM DD

Referring Physician Information:	**Patient Information:**
Name: Specialty: Address: Phone: Fax: Email: Billing #: Signature: **Family Physician Information** (if different) Name: Phone:	Name: Address: Date of Birth: Health Card #: VC: Gender: Male / Female Language if unable to speak English: Phone (Home): Phone (Work): Phone (Cell): Email:

DIAGNOSIS (circle all that apply):

Hip: Right / Left
Knee: Right / Left

Osteoarthritis
Inflammatory arthritis
Fracture/Post-traumatic arthritis
Painful hip or knee replacement
Joint derangement NYD

CONSIDERATION FOR:

Primary Replacement: Hip / Knee
Opinion on prior replacement: Hip / Knee
Non-Surgical Opinion: Hip / Knee

PLEASE ATTACH EXISTING X-RAY REPORTS OF THE AFFECTED JOINT:
If no X-ray report is available within the last 3 months, x-rays will be repeated at Humber

PAST MEDICAL HISTORY:	**CURRENT MEDICATIONS**:

810 Wilson Avenue Toronto, ON M3K 1E5 | **P:** 416.636.8626 | **F:** 416.636.8628 | Sebastian@RHKsurgery.com | **RHKsurgery.com**