Alberta Health Services

Hip and Knee Replacement Referral

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X)	

Please print, complete and return this form by fax to the appropriate clinic.

Clinic Fax

To confirm fax numbers and other clinic information, visit https://albertareferraldirectory.ca and search for **Alberta Hip and Knee Program**

Attach the following with the completed form

- Relevant medical history/EMR Record
- X-ray report - **MRI is not required for this referral**
  Knee: AP weight bearing, lateral of knee with knee flexed, Skyline
  Hip: AP pelvis centered at pubis, AP and lateral of proximal half of affected femur

Patients must be on appropriate non-surgical treatment prior to evaluation *(e.g. medication, physiotherapy, walking aids, shoe inserts).*

Reason for Referral

What is the primary reason you are referring this patient?

Primary Affected Joint(s) ✔	Right	Left	Bilateral
Hip			
Knee			

Type of Problem
☐ Primary
☐ Revision

Duration of Symptoms
☐ 3 - 6 months ☐ 6 - 12 months
☐ Years ☐ Other *(specify)* _____

Is this a WCB claim?
☐ No
☐ Yes, specify claim number _____

Will you be assigning the patient to the next available surgeon?
☐ No, specify surgeon name *(last, first)* _____
☐ Yes

Height _____ cm | Weight _____ kg | BMI _____

Previous Orthopaedic Surgeries

Has the patient undergone any previous orthopaedic surgeries?
☐ No
☐ Yes, complete ▶

Surgery	Surgeon	Year

Is the patient currently controlling joint pain with medication? ▶
☐ No ☐ Yes, complete

☐ Narcotics ☐ Over the counter ☐ NSAID/COXIB
☐ Other *(specify)* _____

Comments

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Check appropriate boxes	None	Mild	Moderate	Severe
Pain on motion *(e.g. walking, bending)*				
Pain at rest *(e.g. while sitting, lying down, or causing sleep disturbance)*				
Other functional limitations *(e.g. putting on shoes, managing stairs, sitting to standing, sexual activity, bathing, cooking, recreation or hobbies)*				
Abnormal findings on physical exam related to most severely affected joint *(e.g. deformity, instability, leg length difference, restriction of range of motion on exam)*				

Highest level of walking supports *(for the affected joint that patient currently uses to carry out usual activities e.g. work, leisure)*

☐ None/Orthotics ☐ Brace/Cane ☐ Crutches/Walker ☐ Wheelchair

Highest level of medication to manage affected joint

☐ PRN pain medication

☐ Regularly-scheduled medication use

☐ Maximum medical therapy appropriate for patient

Ability to walk without significant pain

☐ Over 5 blocks ☐ 1-5 blocks ☐ Less than 1 block ☐ Household ambulator

Threat to patient role and independence in society *(i.e. ability to work, give care to dependents, live independently*)
Must relate to affected joint

☐ Not threatened but more difficult

☐ Threatened but not immediately

☐ Immediately threatened or unable

Rate the level of medical complexity of the patient *(based on number and/or severity of key comorbid conditions, excluding hip/knee condition)*

☐ No medical problems

☐ Current mild medical problems or past significant medical problems

☐ Moderate medical disability or morbidity/requires “first line” therapy

☐ Severe/constant significant disability/“uncontrollable” constant medical problems

☐ Extremely severe/immediate treatment required/end organ failure/severe impairment of function

Referring Clinician Information ***(complete or use practice stamp below)***		
Name	PRACID	Practice Stamp *(if applicable)*
Address		
Phone	Fax	
Signature	Date *(yyyy-Mon-dd)*	