Comprehensive Osteoarthritis Management, Education & Treatment Clinic

Please complete and return this form by fax to 780-244-6842

Referral Date:

Referring Physician Information:

Name: ___________________________

Specialty: ________________________

Address: __________________________

Phone: ____________________________

Fax: ______________________________

Signature: __________________________

Family Physician Information (if different):

Name: _____________________________

Phone: _____________________________

Patient Information:

Name: ___________________________

Address: __________________________

Date of Birth: _______________________

Health Card #: _______________________

Patient Gender: ☐ Male ☐ Female

Occupation: _________________________

Phone (Home):_______________________

Phone (Cell): ________________________

Email: _____________________________

Reason for Referral/ Affected Joints: (check all that apply):

☐ Hip Right/Left ☐ Shoulder Right/Left

☐ Knee Right/ Left ☐ Ankle Right/Left

PLEASE ATTACH EXISTING X-RAY REPORTS OF THE AFFECTED JOINT

If no X-ray is available within the last 6 months, we recommend the following views: Knee: AP weight bearing, lateral of knee flexed at 30, skyline | Hip: AP pelvis, AP and lateral of affected hip

CURRENT SYMPTOMS (check all that apply)

☐ Locking

☐ Instability/giving way

☐Pain with activity:

☐Mild ☐Moderate ☐ Severe

☐ Pain at rest/night:

☐Mild ☐Moderate ☐ Severe

☐ Other:

____

TREATMENTS TO DATE (check all that apply)

☐ Analgesics

☐ Non-steroidal anti-inflammatory drugs

☐ Injections: O Steroid

O Viscosupplement

☐ Hyaluronic Acid

☐ Platelet Rich Plasma

☐ Stem Cells

☐ Physiotherapy

☐ Exercise/weight loss

☐ Tylenol

☐ Bracing/ Orthotics

☐ Other: __________________

EFFECTS: (Please Circle)

Good Relief

Moderate Relief

No Relief

Not Tried

Previous Surgery History: (Please include dates):

____

CURRENT MEDICATIONS: (please list or attach medication profile):

____

Past Medical History:

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