

**Hip and Knee Assessment Referral Form**

**Referral Date:** \_\_\_\_\_

**Consultation and Fax numbers**

Location/Surgeon option (choose **only one** option - 1, 2 or 3)

- 1. Preferred RJAP surgeon (view page 2 for a list of surgeons and **fax numbers**) Dr. \_\_\_\_\_
- 2. First available RJAP assessment date (assessment will be at any of the RJAP locations) - **Fax to 905 521-2621**
- 3. Preferred Hospital (First available surgeon will be selected) Choose location and **fax to 905 521-2621**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Juravinski Hospital (Hamilton)   | <input type="checkbox"/> Brantford General Hospital         | <input type="checkbox"/> Greater Niagara General Hospital |
| <input type="checkbox"/> St. Joseph's Healthcare Hamilton | <input type="checkbox"/> Joseph Brant Hospital (Burlington) | <input type="checkbox"/> Welland General Hospital         |
|   |   | <input type="checkbox"/> St. Catharines General Hospital  |

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Male  Female   
 Health Card # \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**Clinical Information**

**Affected Joint(s):** Hip:  Right  Left  Bilateral      Knee:  Right  Left  Bilateral  
**Diagnosis**  Osteoarthritis       Inflammatory Arthritis       Other \_\_\_\_\_  
 WSIB Patient:  Y  N      WSIB # \_\_\_\_\_

**Referring Physician Information**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 OHIP Billing #: \_\_\_\_\_ Physician signature \_\_\_\_\_

**X-ray Requirements**

This referral form must be completed and faxed with the required x-ray report. These x-rays allow for appropriate triaging and diagnosis. **An MRI is not appropriate.**  
 X-rays, completed at any HNHB hospital, can be accessed by the RJAP health team on *OneView*. If the x-ray is completed at a private clinic, patients are required to bring their x-rays with them on CD or film to their assessment.  
 The following x-rays are to be taken and then reviewed by the referring physician, both within the last 6 months:  
**Knee - Standing AP, lateral and skyline**      **Hip - Ortho pelvis, AP and lateral shoot through**

**Medications and Medical History**

Attach the cumulative patient profile and medical history.

**Regional Joint Assessment Program  
Option 1**
**Participating Orthopedic Surgeons**
**Juravinski Hospital (Hamilton)**
**Fax to 905 521-2621**

Dr. V. Avram                      Dr. M. Winemaker  
Dr. J. de Beer  
Dr. D. Tushinski  
Dr. D. Williams

For booking inquiries, call:  
905 577-8472 or 1 888-868-5568

**St. Joseph's Healthcare Hamilton**

Dr. A. Adili                      **Fax to 905 540-6577**  
Dr. V. Khanna                      **Fax to 905 540-6599**

For booking inquiries, call:  
905 522-1155 ext. 32907

**Greater Niagara General Hospital**
**Fax to 905 521-2621**

Dr. L. Bristow                      Dr. C.M. Offierski  
Dr. B. Le Roux                      Dr. J. Ostrowski  
Dr. L. Flores

For booking inquiries, call:  
905 378-4647 ext. 53110

**Welland General Hospital**
**Fax to 905 521-2621**

Dr. M. Gunton                      Dr. J. Song

For booking inquiries, call:  
905 378-4647 ext. 53110

**St. Catharines General Hospital**
**Fax to 905-521-2621**

Dr. D. Martin                      Dr. C. Robert

For booking inquiries, call:  
905 378-4647 ext. 53110

**Brantford General Hospital**

Dr. J. Dill                      **Fax to 1-519-304-5533**  
Dr. M. Woolfrey                      **Fax to 1-519-900-2227**

For booking inquiries, call:  
519 751-5544 ext. 2267

**Joseph Brant Hospital (Burlington)**

Dr. D. Armstrong                      **Fax to 905 333-9775**  
Dr. A.J Pyper                      **Fax to 905 333-1474**

For booking inquiries, call:  
905 577-8472 or 1 888-868-5568