WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
M5S 1B2

SURGICAL SERVICES AMBULATORY PRIMARY TOTAL JOINT PROGRAM HIP AND KNEES REFERRAL FORM

REFERRAL DATE: ____/____/______
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:____________ HCN:______________________
Name:______________________________________
Sex:__________ Date of Birth: ____/____/______ (DD / MM / YYYY)
Address:____________________________________
Telephone:______________ Alternate #:____________

Please check the specific surgeon's name below:

☐ **Dr. Paul Kuzyk** (Mount Sinai Hospital) Fax Referrals to: 416-586-8673 | Office Phone: 416-586-4653
Area of Expertise: Minimally invasive total hip replacement, total knee replacement

☐ **Dr. Oleg Safir** (Mount Sinai Hospital) Fax Referrals to: 647-826-8019 | Office Phone: 416-586-4653
Area of Expertise: Minimally invasive total hip replacement

☐ **Dr. Jesse Wolfstadt** (Mount Sinai Hospital) Fax Referrals to: 416-586-8678 | Office Phone: 416-586-4800 ext. 2835
Area of Expertise: Total knee replacement, partial knee replacement

☐ **Dr. Michael Zywiel** (Toronto Western Hospital) Fax Referrals to: 416-603-3437 | Office Phone: 416-603-5359
Area of Expertise: Total knee replacement, partial knee replacement, direct anterior (DAA) total hip replacement

ADDITIONAL PATIENT INFORMATION

Preferred name: Gender (*if not same as above*):
Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ ______________
Other insurance coverage (IFH, UHIP, etc.): ☐ Self-pay
Language spoken: Interpreter required: ☐ Yes ☐ No
Allergies and reaction:

REFERRING PROVIDER INFORMATION

Name:	Billing #: ______________
Address:	
Telephone:	Signature: ______________
Fax:	

☐ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: ______________ Phone:__________ Fax:__________

REASON FOR REFERRAL

Diagnosis and/or chief complaint:

Previous management:

X-RAY REPORTS OF THE AFFECTED JOINT MUST ACCOMPANY REFERRAL
If no X-ray report is available from within the the last 6 months, we recommend the following views:
Knee: Anterior posterior (AP) weight bearing, lateral of knee flexed at 30º, skyline
Hip: Anterior posterior (AP) Pelvis, Anterior posterior (AP) of affected hip and cross table lateral
Patients are required to bring their X-Rays to their appointment.
In the setting of osteoarthritis, MRI is not recommended.

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Address: ____

Telephone: _________________ Alternate: ______________

CURRENT SYMPTOMS (check all that apply)

☐ 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 ☐ Steroid ☐ Viscosupplement
☐ Arthroscopy ☐ Physiotherapy ☐ Exercise/weight loss
☐ Other: ____________________

CURRENT ASSISTIVE DEVICES

☐ None ☐ Cane(s) ☐ Crutches
☐ Rollator/Walker ☐ Wheelchair

MEDICATIONS AND MEDICAL HISTORY
(please attach patient profile)

Has there been a recent significant change in function, pain level and/or range of motion? ☐ Yes ☐ No
Are there systemic signs (e.g., fever, chills)? ☐ Yes ☐ No
Other significant issues? ____
____