Oshawa Clinic Group

Lakeridge Health

Orthopaedic Joint Assessment Clinic
Phone: 905-576-8711 ext. 3243
Fax: 905-721-4844

Patient Label

Date: _____
Primary Contact #:_____

FOR NEW PATIENTS **ONLY**

REFERRAL SOURCE
MD/NP_____
MD OHIP BILLING#_____
Phone: _____
Fax: _____

WSIB YES ☐ NO ☐
WSIB CLAIM #
_____
Height:_____ Weight: _____

X-RAY and RADIOLOGY REPORT TO BE ATTACHED (WITHIN 6 MONTHS) *MRI not required, and will be recommended if needed.*
Clinical Question: Query Osteoarthritis
Knee: Views: bilateral PA Standing, bilateral PA Standing 30° Flexion, affected Lateral, and affected Skyline

SURGEON
Assign next available Surgeon YES ☐ NO ☐ ***or*** Preferred Surgeon: _____
(if preferred surgeon, wait time cannot be guaranteed)

REASON FOR REFERRAL ☐ Primary ☐ Revision

☐ Primary ☐ Revision
Affected Joint(s) Hip L ☐ R ☐ Bilateral ☐ Known arthritis ☐
Knee L ☐ R ☐ Bilateral ☐ Previous orthopaedic surgery on affected joint ☐
Diagnosis: _____

CURRENT SYMPTOMS
Pain with activity MILD ☐ MODERATE ☐ SEVERE ☐
Pain with rest/night MILD ☐ MODERATE ☐ SEVERE ☐
Other: _____

Duration of Symptoms: _____

TREATMENT
☐ Acetaminophen
☐ NSAID
☐ Opioids
☐ Steroid Injection date: _____
☐ Viscosupplementation date: _____
☐ Athroscopy date: _____
☐ Physiotherapy
☐ Cane(s)/Walker
☐ Braces
☐ Exercise
☐ Weight Loss
☐ Other: _____

PMHX (please note, or attach complete EMR profile)
Cardiovascular _____ RESP _____ENDOCRINE_____GI _____HEENT_____
GU_____MSK_____NEURO_____AUTOIMMUNE_____DIABETES_____
OTHER_____
ALLERGIES NO ☐ YES ☐ List _____
Please attach complete current medication list