



Hip and Knee Assessment Referral Form

Referral Date: currentDate.yyyysmmsdd

Consultation

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

☐ Juravinski Hospital (Hamilton)
☐ St. Joseph's Healthcare Hamilton

☐ Brantford General Hospital
☐ Joseph Brant Hospital (Burlington)

☐ Greater Niagara General Hospital
☐ Welland General Hospital
☐ St. Catharines General Hospital

Patient Information

Last Name: patSurname First Name: patFirstName Male ☐ Female ☐
Health Card # patHN Date of Birth: patBirthdate.yyyysmmsdd
Address: patStreetAddress City: patCityAddress
Postal Code: patPostalCode Phone: patHomePhone.default

Clinical Information

Affected Joint(s): **Hip:** ☐ Right ☐ Left ☐ Bilateral **Knee:** ☐ Right ☐ Left ☐ Bilateral
Diagnosis ☐ Osteoarthritis ☐ Inflammatory Arthritis ☐ Other _____
WSIB Patient: ☐ Yes ☐ No WSIB # _____

Referring Physician Information

Name: patFam.fullName Address: patFam.addressLabel
City: patFam.city Postal Code: patFam.postalCode
Phone: patFam.phone.default Fax: patFam.fax.default
OHIP Billing #: patFam.physNum Physician signature

X-ray Requirements

This referral form, must be completed and sent 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. D. Williams
Dr. J. de Beer	Dr. M. Winemaker
Dr. B. Deheshi	Dr. D. Wismer
Dr. D. Punthakee	

St. Joseph's Healthcare Hamilton

Fax to 905 540-6577

Dr. A. Adili

Greater Niagara General Hospital (Niagara Falls)

Fax to 905 521-2621

Dr. J. Ostrowski
Dr. B. Le Roux
Dr. C.M. Offierski

Welland General Hospital (Welland)

Fax to 905 521-2621

Dr. J. Song
Dr. M. Gunton

St. Catharines General Hospital

Fax to 905-521-2621

Dr. D. Martin

Brantford General Hospital

Dr. J. Dill
Dr. M. Woolfrey

Fax to 519 756-5576

Fax to 519 751-5895

Joseph Brant Hospital (Burlington)

Dr. A.J. Pyper
Dr. D. Armstrong

Fax to 905 333-9775

Fax to 905 333-1474



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The Willett, Paris
The Brantford General



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