NEJAC | CÉANE
NORTH EAST JOINT ASSESSMENT CENTRE | CENTRE D'ÉVALUATION DES ARTICULATIONS DU NORD-EST

RAPID ACCESS CLINIC – NEJAC REFERRAL FORM

Ontario

REFERRAL DATE:

Please fax the completed referral to CENTRAL INTAKE
Fax: 1-855-567-7969 **Phone : 1-855-653-7966**

ASSESSMENT: Your patient will be assessed at the NEJAC closest to their home.

CONSULT: When your patient has been determined to be a Surgical candidate they will be given the option to select a **specific surgeon** or the **Next available surgeon** (specific site or NELHIN).
Surgeon Preference (if appropriate):

PATIENT INFORMATION (sticker)	REFERRING PHYSICIAN INFORMATION (sticker)
Name:	Name:
Address:	Address:
City, Postal code:	Phone: Fax:
DOB: DD MM YYYY:	Specialty: .
Gender: ☐ Male ☐ Female	OHIP Billing Number: .
Health Card Number:	**Family Physician Information** (if different from above)
Phone: Alternate Phone/Contact:	Name:

CLINICAL INFORMATION

Joint(s): HIP ☐Left ☐ Right ☐ Bilateral
KNEE ☐Left ☐ Right ☐ Bilateral
SHOULDER ☐Left ☐ Right ☐ Bilateral

Level of Pain: ☐ Mild ☐ Moderate ☐ Severe

Functional Limitation: ☐ Mild ☐ Moderate ☐ Severe

Diagnosis:
- ☐Osteoarthritis
- ☐ Painful TKR/THR
- ☐Inflammatory Arthritis
- ☐ Frozen Shoulder
- ☐Impingement syndrome
- ☐ Instability
- Rotator cuff tear:
  - ☐Partial thickness
  - ☐Full thickness
- ☐OTHER:

DIAGNOSTIC IMAGING REQUIREMENTS

ATTACHED: ☐ Yes ☐ Pending

Knee: Bilateral Weight Bearing AP at 0° & 30° flexion, lateral and skyline of affected knee(s)

Hip: AP pelvis, AP & lateral of affected hip(s)

Previous THR: above views + AP of proximal half of femur (ensure stem is visible)

Shoulders A/P in neutral, Transcapular, Axillary and Outlet

- X-Ray within **last 6 months,**
- US or MRI for shoulders only
- MRI is **NOT** recommended for initial screening of OA

Is this condition covered under WSIB? ☐ Yes ☐ No

CURRENT MEDICATIONS LIST

ATTACHED: ☐ Yes ☐ No

NOTE: If not attached please inform patient to bring list to first NEJAC appointment.

ADDITIONAL IMAGING / PHYSIOTHERAPY NEEDS:

I am referring this patient to the Rapid Access Clinic (NEJAC) and authorize:

☐Yes ☐ No Transfer of authority to order and follow up on additional x-ray imaging for my patient to an Advanced Practice Physiotherapist as they deem clinically appropriate

☐Yes ☐ No Use of this referral to refer my patient to outpatient physiotherapy services as deemed clinically appropriate

PCP Signature: **Date:**

"This referral form has been adapted for the NELHIN with permission from Sunnybrook Holland Orthopaedic & Arthritic Centre 2010"