WATERLOO WELLINGTON Coordinated Access

Waterloo Wellington Referral Coordination Centre
Fax Completed Form to **1-877-555-5555**

Orthopedic Assessment Referral Form

Patient Information	
Name:	DOB: DD/MM/YYYY
Address:	HC#:
Phone 1:	Phone 2:
Alternate Contact:	

☐ **Next Available** *or* Preferred Surgeon: _____

Reason for Referral	
Diagnosis: ☐ Osteoarthritis ☐ Inflammatory Arthritis (RA, SLE, Gout) ☐ Other:	
Affected Joints	**Required X-Ray Views:**
Hip: ☐ L ☐ R	AP pelvis centred at pubis, AP and lateral of proximal half of affected femur
Knee: ☐ L ☐ R	PA standing lateral, Skyline
Foot: ☐ L ☐ R	AP weight-bearing lateral of foot
Ankle: ☐ L ☐ R	AP weight-bearing lateral of foot
Shoulder: ☐ L ☐ R	AP/lateral of shoulder
Wrist: ☐ L ☐ R	AP/lateral of wrist
Spine: ☐	
Level of Pain: ☐ Mild ☐ Moderate ☐ Severe	**Functional Limitation:** ☐ Mild ☐ Moderate ☐ Severe

Additional Information	
Co-Morbidities:	
Current Medications:	
Comments:	

Referring Practitioner Information	
Name:	Billing Number:
Address:	
Phone:	Fax:
Date: DD/MM/YYYY	Signature:

Current X-Ray Report(s) Attached: ☐