Champlain Regional Orthopaedic Network
ChamplainMSKcare

www.champlainmskcare.ca
Fax: 613-721-7889

Referral Form – Central Intake Knee Conditions

***This referral is <u>not</u> to be used for urgent referrals**

Referral Date (YYYY/MM/DD):

Referral Options: Please indicated patient preference for

□ First Available Surgeon or □ Specific Surgeon: _____

□ Specific Hospital: □ Cornwall □ Montfort □ Pembroke □ Queensway Carleton □ TOH

Referring Physician Information – may use stamp

Name: _____
Address: _____
_____
Phone: _____
Fax: _____
Billing #: _____

Signature: _____

Patient Information – may use sticker

Name: _____
Address: _____
_____
Phone: _____
DOB: _____
Health Card #: _____
Gender: □ Male □ Female

Reason for Consultation:

Knee: □ Left □ Right

Diagnosis:

□ Meniscal Tear (must have no more than mild OA) □ Loose Bodies (must have no more than mild OA) □ Patello-Femoral Instability

□ ACL Tear (primary) □ ACL re-Tear (revision) □ Knee Malalignment

□ Cartilage Injury (must have no more than mild OA) □ Multi-Ligament Injury □ Other: _____

Injury Details (If Appropriate): _____
_____
_____

Current Symptoms (Check All That Apply):

□ Pain □ Swelling
□ Locking □ Instability

Treatments to Date:

□ NSAIDs □ Physiotherapy □ Bracing
□ Injections □ Surgery _____

Imaging Reports (Must Accompany Referral):

□ X-rays* □ MRI □ CT

*If the patient is >40 years old, first diagnostic test must be <u>WEIGHT BEARING</u> knee X-rays: PA standing flexion, AP, lateral and skyline views.

If the patient has > mild knee OA, please refer to the Regional Hip and Knee Replacement Program.

Please attach any additional information as required.