

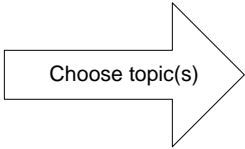
Education Requests - Complete Sections 1 & 2.
 Assessment Requests - Complete Sections 1 & 3.
 Education & Assessment Requests - Complete Sections 1, 2 & 3.

Please assist us in providing service to your patient by completing all relevant information.

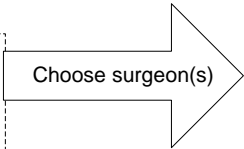
Section 1: Patient Demographics This section must be completed for all requests.

Patient Name: _____ <small>Surname First Name Initial</small>		OASIS Pt ID:
Address: _____		PHN:
City: _____	Postal Code: _____	PCP Chart No:
Telephone - Home: _____	Cell: _____	Birthdate (dd/mm/yy):
Telephone - Work: _____	Pager: _____	Age: _____ Sex: _____
Does patient speak/understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, language spoken: _____		
If no, alternate contact (name/number): _____		
Referring Provider: _____	Phone: _____	Fax No: _____
Primary Care Physician (if different from above): _____	Phone: _____	Fax No: _____
Affected Joints: <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee		

Section 2: Request for Education Information is available in group education sessions and/or written material.

<input type="checkbox"/> Education Session (as available)		<input type="checkbox"/> Intro to OA/Joint Protection (included info on assistive devices/ADLs)
<input type="checkbox"/> Written Material		<input type="checkbox"/> Pain Management <input type="checkbox"/> Exercise
		<input type="checkbox"/> Nutrition/Supplements <input type="checkbox"/> Weight Management
		<input type="checkbox"/> Other (specify) _____
Additional comments: _____		

Section 3: a) Request for ASSESSMENT APPOINTMENT

<p>Choose Assessment Type:</p> <input type="checkbox"/> Assessment - Non-operative <input type="checkbox"/> Assessment - Possible Surgery <input type="checkbox"/> Assessment for Surgery (within 2-6 months) <input type="checkbox"/> Assessment for Urgent Surgery (within 8 weeks) Note: Please attach any consult reports.		<p>1st Available Surgeon in:</p> <input type="checkbox"/> Region <input type="checkbox"/> Vancouver <input type="checkbox"/> Richmond <input type="checkbox"/> North Shore or Name of Preferred Surgeon(s): _____
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Referrals from Surgeons:

Has surgical consult taken place? Yes No **Note:** Clients waiting for/ or requiring surgical consult will be redirected back to referring surgeon.

If yes, is client a surgical candidate? Yes No

Choose who will coordinate assessment recommendations: (Note: If surgeon referring client, PCP will be contacted to answer this question.)

OASIS to coordinate care (I.e.: Initiate recommendations with client - forward referrals requiring physician signature to PCP)
 Primary Care Physician to coordinate care (I.e.: Action Plan will be forwarded to PCP to initiate recommendations with client.)

X-Rays REQUIRED for assessments. See reverse side of the form for accepted X-ray views.

Facility where recent x-ray available (taken within past year): _____

Note: A copy of the x-ray report must be submitted with the referral form.

Check here if new x-ray required. OASIS will initiate X-ray Requisition form for PCP to sign.

Sign here for Education AND/OR Assessment requests. If you are requesting Assessment please continue to page 2.

Physician Signature: _____ **Date:** _____

OASIS Referral Form Instructions

DO NOT FAX THIS SIDE when referring patients to OASIS. This is an Informational page for your use.

Request for Education

Your patient does not need to have an assessment with OASIS to receive information. You may refer them to OASIS for Information Only. Information is available via Group Education Sessions or Written Material.

To request Education Only complete sections 1 and 2 of the Physician Referral Form, sign it and fax the form to the appropriate OASIS clinic.

Please Note: Referrals can not be processed unless all information is complete.

Request for Assessment Appointment

To request an assessment appointment for your patient complete sections 1 and 3 of the Physician Referral Form, sign it and fax the form to the appropriate OASIS clinic. You may also complete section 2 if you would like to specify information you would like your patient to receive.

Items of Note when completing sections:

- Specify assessment type
- If surgical, or possible surgical, please indicate 1st available or preferred surgeon(s)
- Specify who will coordinate care
- An x-ray is required during the assessment appointment.
 - If your patient has had an x-ray in the past year, indicate the facility where the x-ray is available. OASIS will arrange to have the x-ray forwarded to the clinic for the scheduled appointment.
 - If your patient does NOT have a recent x-ray (within one year), indicate that a new x-ray is required. OASIS can assist by generating an X-ray Requisition for you to sign and give to your patient.
- Indicate the affected joint or joints.
- Indicate any pertinent health history the OASIS clinicians should know about.
- Record current arthritis prescription medications; discontinued/failed arthritis medications and non-prescription medications you are aware of.
- Complete the Referral Prioritization Tool. This tool will assist us in scheduling your patient based on need. (Note: Although the score from this tool will identify patients with an urgent need, we will also refer to the assessment type you have chosen to further identify urgency.)
- Don't forget to sign the referral form

Please Note: Referrals can not be processed unless all information is complete.

X-RAY Information

OASIS requires a recent x-ray and x-ray report during the assessment appointment. Recent x-rays include those taken within the past year. Following are the types of x-ray views identified by surgeons as appropriate.

Knee X-Ray views include:

- ✓ AP weight bearing of both knees
- ✓ Skyline (patella) of affected side
- ✓ Lateral Knee w/knee flexed at 90 degrees

Hip X-Ray views include:

- ✓ AP weight bearing of both hips
- ✓ AP pelvis centered at pubis to show proximal 1/3 both femurs
- ✓ Shoot through lateral of the affected hip and proximal femur

OASIS Clinics - Contact Information

Choose which Clinic your patient wants to attend. If the chosen clinic is not available within set time frame patient will be given the option to attend an alternate clinic.

Vancouver Clinic	Fax: 604.875.8294	Phone: 604.875.4544
Richmond Clinic	Fax: 604.675.3943	Phone: 604.675.3944
Coastal (North Shore) Clinic	Fax: 604.904.6170	Phone: 604.904.6177

*** New Referral Forms available on the OASIS website at www.vch.ca/oasis or by calling 604-875-4257.**

For more information, please call the OASIS Regional Office at 604-875-4257 or visit www.vch.ca/oasis

Section 3: b) Request for ASSESSMENT APPOINTMENT Continued

Referral Prioritization Tool (WCWL Extended Tool)

Please check the box that most accurately describes the patient's situation over the last three months. If more than one joint is involved, answer for the most severely affected joint. (Guide attached)

- 1) Pain on motion (e.g.: walking, bending, etc.):
 None/mild Moderate Severe
- 2) Pain at rest (e.g.: while sitting, lying down, or causing sleep disturbance):
 None Mild Moderate Severe
- 3) Ability to walk without significant pain:
 Over 5 blocks 1-5 blocks Less than 1 block Household ambulation
- 4) Other functional limitations (e.g.: putting on shoes, managing stairs, sitting to standing, sexual activity, bathing, cooking, recreation or hobbies):
 No limitations
 Mild limitations - able to do most activities with minor modification or difficulty
 Moderate limitations - able to do most activities with modification or assistance
 Severe limitations - unable to perform most activities
- 5) Abnormal findings on physical exam related to affected joint (e.g.: deformity, instability, leg length difference, restriction of range of motion on examination):
 None/mild Moderate Severe
- 6) Highest level of walking supports (related to the affected joint) that patient currently uses to carry out usual activities (e.g.: work, leisure):
 None/Orthotics Brace / Cane Crutches / Walker Wheelchair
- 7) Highest level of medication to manage affected joint:
 PRN pain medication Regularly scheduled medication use Maximum medical therapy appropriate for this patient
- 8) Threat to patient role and independence in society (e.g.: ability to work, give care to dependents, live independently - difficulty must be related to affected joint, assume that where role is threatened, patient is motivated to change):
 Not threatened but more difficult Threatened but not immediately Immediately threatened or unable
- 9) All things considered, how would you rate the urgency or relative priority of this patient to be seen by the specialist? (Put an X in the relevant position on the scale.)

Not Urgent _____	Extremely Urgent (just short of an emergency)
at all	

<p>Previous Arthroplasties:</p> <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee	<p>Health History:</p> <input type="checkbox"/> Cardiac <input type="checkbox"/> DVT / PE <input type="checkbox"/> Hematological <input type="checkbox"/> Mental Illness <input type="checkbox"/> Neuro <input type="checkbox"/> Respiratory <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hypertension <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Diabetes <input type="checkbox"/> Renal <input type="checkbox"/> Gastric/Intestinal <input type="checkbox"/> CVA <p>Comments: _____</p>
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<p>Current Arthritis Medications: (OASIS to validate with Pharmanet)</p> <ul style="list-style-type: none"> • Over the counter drugs • Rx NSAIDs / COX-2s • Narcotics • Immunosuppressants • Other Relevant Drugs for Arthritis (e.g.: Steroids; Neurontin; etc.) 	<p>Current Arthritis Prescription Medications:</p> <hr/> <hr/> <hr/> <hr/>	<p>Discontinued/Failed Arthritis Meds:</p> <hr/> <hr/> <hr/> <hr/>	<p>Non-Prescription Medications:</p> <hr/> <hr/> <hr/> <hr/>
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Additional comments: _____

Sign and Fax to appropriate Clinic. Clinics listed on reverse of form.

Physician Signature: _____ **Date:** _____