Vancouver CoastalHealth

**COMPLEX JOINT (RECONSTRUCTIVE) CLINIC**
3rd Floor, Station #3 - Diamond Centre
2775 Laurel Street
Vancouver, BC V5Z 1M9

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# COMPLEX JOINT (RECONSTRUCTIVE) CLINIC REFERRAL

Referral to: ☐ Dr. Michael E. Neufeld ☐ Dr. Nelson V. Greidanus ☐ Dr. Lisa C. Howard (Fax referral to: 604-398-4936)
☐ Dr. Donald S. Garbuz ☐ Dr. Bassam A. Masri (Fax referral to: 604-732-6286)

**PLEASE PRINT CLEARLY** ☐ ALLERGIES (PLEASE LIST):

| | |
|---|---|
| BILLABLE TO:<br>☐ MSP ☐ ICBC ☐ WCB ☐ PATIENT ☐ OTHER | NAME / ADDRESS OF REFERRING PHYSICIAN AND MSP PRACTITIONER # (or office stamp) |
| PERSONAL HEALTH NUMBER: / DOB: YYYY /MM/DD | |
| SURNAME OF PATIENT, FIRST NAME AND MIDDLE INITIAL | |
| TELEPHONE# (INCLUDE AREA CODE): HOME / CELL<br>☐ MALE ☐ FEMALE<br>PREGNANT: ☐ YES ☐ NO | FAX#: |
| EMAIL: | |
| ADDRESS / CITY/TOWN / POSTAL CODE | COPY RESULTS TO: |

☐ TRANSLATION SERVICES REQUIRED: (PLEASE INDICATE LANGUAGE): _____
(24 HOUR ADVANCED NOTICE REQUIRED)

## PERTINENT HISTORY

REASON FOR REFERRAL: _____

BRIEF HISTORY AND FINDINGS: _____

**ALL REFERRAL INFORMATION MUST BE COMPLETED IN FULL. INCOMPLETE REFERRALS WILL BE RETURNED TO BE COMPLETED.**

***ALL REFERRALS MUST INCLUDE AN EMAIL AND A RADIOLOGY REPORT SUPPORTING THE REFERRAL. REFERRALS ARE NOT ENTERED WITHOUT THIS ATTACHED**

***ALL REFERRALS MUST INCLUDE HEIGHT & WEIGHT** HEIGHT: _____ WEIGHT: _____

HAS THE PATIENT HAD PREVIOUS ARTHROPLASTY: ☐ YES ☐ NO

If YES, PLEASE ATTACH ANY OF THE FOLLOWING:
- Operative reports and implant labels from previous joint replacement
- All recent blood/laboratory/pertinent results
- If no recent blood work, please order a CRP blood test for your patient

**THIS REFERRAL MUST BE RELATED TO SURGICAL CONSULTATION FOR,HIP AND/OR KNEE RECONSTRUCTION.**
**WE SEE PATIENTS FOR THE FOLLOWING:**
**OSTEOARTHRITIS, HIP DYSPLASIA, FAILED ARTHROPLASTY (REVISIONS), AVASCULAR NECROSIS, AND HEMI-ARTHROPLASTY.**
**WE DO NOT SEE PATIENTS FOR:**
**SOFT TISSUE INJURIES, MENISCAL/LABRAL TEARS, ACL, BUNIONS, SHOULDERS, ANKLES, OR SPINAL INJURIES**

## PLEASE NOTE

ACKNOWLEDGEMENT OF REFERRAL

☐ Received. Please note the standard wait time for consultation is _____ *months* from the original referral date.
***The wait time can fluctuate each month.*** Our office will notify the patient one month prior his/her appointment.

☐ We require additional information for the above patient. Please update and refax.
☐ Radiology report ☐ Medical Images (CD of x-ray or films)

☐ This patient is not an appropriate candidate for our clinic. Please re-direct the referral to: _____

OUR FACILITY IS A FRAGRANCE FREE ZONE