

Section 1: PATIENT DEMOGRAPHICS

Last Name:	First Name:
Address:	PHN:
City:	DOB:
Postal Code:	Gender:
Phone (Home):	Phone (Other):
	Email:

Does the client speak/understand English? Yes No If no, language spoken:
If no, please provide an alternate contact (name/number):

Section 2: SERVICE REQUESTED

Referring Clinician:	MSP ID:	Phone:	Fax:
Primary Care Provider: (if different from above)	MSP ID:	Phone:	Fax:

Priority Joint:

For: Assessment - Conservative Management **Surgical Consult Options**
 Assessment - Surgical or Possible Surgery 1st available Surgeon in:
 Assessment - Surgical Urgent **OR: Name of Preferred Surgeon(s)**

OASIS education classes do not require a physician referral. We offer the following classes: Understanding Osteoarthritis, Osteoarthritis and Exercise, Pole Walking, Nutrition and Supplements/Weight Control, Mindful Eating for Weight Control (2 Part Class), Pain Management, Sleep/Stress Management, Hand Osteoarthritis, and Foot/Ankle Osteoarthritis. Available sessions can be found on oasis.vch.ca

Has the patient already been referred for a surgical consult?	Yes	No
If yes, surgeon:		
Joint:		
If yes, has surgical consult taken place?	Yes	No
If yes, is client a surgical candidate?	Yes	No

Other Affected Joints:	L. Hip	L. Knee	L. Ankle	L. Foot	L. Hand	L. Wrist	L. Elbow	L. Shoulder
	R. Hip	R. Knee	R. Ankle	R. Foot	R. Hand	R. Wrist	R. Elbow	R. Shoulder

Section 3: IMAGING REQUIREMENT

Are current (within 1 year) x-rays available?
 Yes - Attach X-Ray Report with this Referral.
 No - Requisition completed and given to patient OR not required because

X-Ray Views	Hip: Standing AP (weight bearing) of pelvis centered low to include prox. 1/3 femur & true lateral of hip	Shoulder AP, LAT, Axillary
	Knee Standing AP (weight bearing) both knees, LAT, Skyline Patella of affected side	Elbow: AP, LAT
	Ankle: Standing AP (weight bearing), lateral, mortise	Hand/Wrist: AP, LAT
	Foot: Standing AP (weight bearing), lateral, oblique	

Coordination of Care (To be completed by the PCP only)	I wish to coordinate any OASIS recommendations and make the surgical referral if required.	OASIS will coordinate the recommendations made during the assessment and make a surgical referral (for hip or knee only) unless the Primary Care Provider indicates otherwise.
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Additional Patient Information

and Fax to: Please remember to attach the X-Ray Report to this referral.

Vancouver Clinic @ 604.875.8294 Date:

Richmond Clinic @ 604.297.9926

North Shore Clinic @ 604.904.6170 Referring Clinician Signature