Vancouver Coastal Health
*Promoting wellness. Ensuring care.*

# OASIS Program Referral Form

Please fill out this form and print & fax or email it to the OASIS Clinic in your region.

OASIS
OsteoArthritis Service Integration System
Working Together for Healthy Joints

## Section 1: PATIENT DEMOGRAPHICS

Last Name: | First Name:

Address: | PHN: | DOB:

City: | Postal Code: | Gender:

Phone (Home): | Phone (Work): | Phone (Cell):

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
- ◯ Assessment - Surgical or Possible Surgery
- ◯ Assessment - Surgical Urgent

Surgical Consult Options
1st available Surgeon in: .
OR: Name of Preferred Surgeon(s)

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

OASIS group education does 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

**Other Affected Joints:**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ L. Hip | ☐ R. Hip | ☐ L. Knee | ☐ R. Knee | ☐ L. Ankle | ☐ R. Ankle | ☐ L. Foot | ☐ R. Foot | ☐ L. Hand | ☐ R. Hand | ☐ L. Wrist | ☐ R. Wrist | ☐ L. Elbow | ☐ R. Elbow | ☐ L. Shoulder | ☐ 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 |
| **Knee** | Standing AP (weight bearing), LAT, Skyline Patella of affected side |
| **Ankle:** | Standing AP (weight bearing), lateral, mortise |
| **Foot:** | Standing AP (weight bearing), lateral, oblique |
| **Shoulder** | AP, LAT, Axillary |
| **Elbow:** | AP, LAT |
| **Hand/Wrist:** | AP, LAT |

**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.

Additional Patient Information

Print and Fax to:
- ☐ Vancouver Clinic @ 604.875.8294
- ☐ Richmond Clinic @ 604.244.5517
- ☐ North Shore Clinic @ 604.904.6170

or Email: E-mail

You have the option to send your completed form to Vancouver Coastal Heath by email or fax. You acknowledge that if you choose to use email, it may not be secure or reliable and you assume all risks associated with its use. VCH does not take any responsibility for ensuring that the form is securely delivered to us.

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

Referring Clinician Signature

Date: