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 (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

◯ 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 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

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) both knees, LAT, Skyline Patella of affected side	**Shoulder**	AP, LAT, Axillary
Ankle:	Standing AP (weight bearing), lateral, mortise	**Elbow:**	AP, LAT
Foot:	Standing AP (weight bearing), lateral, oblique	**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

E-mail

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

Referring Clinician Signature

Date:

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OASIS Radiology Exam Requisition Form

Please fill out this form and give it to your patient.

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Section 1: PATIENT DEMOGRAPHICS

Last Name: First Name:

Address: PHN:

DOB:

City: Postal Code: Gender:

Phone (Home): Phone (Other): Email:

Section 2: COPY TO

OASIS Program - Vancouver Clinic
2775 Laurel Street, Vancouver
Phone: 604.875.4544
Fax: 604.875.8294

OASIS Program - Richmond Clinic
Richmond Hospital, Richmond
Phone: 604.244.5377
Fax: 604.244.5517

OASIS Program - Coastal Clinic
Lions Gate Hospital, North Vancouver
Phone: 604.904.6177
Fax: 604.904.6170

Section 3: NOTE TO PATIENT

Once your X-Ray has been completed, please call the OASIS clinic above to book your appointment.

Section 4: X-RAY SPECIFICATIONS

	Left	Right	X-Ray Specifications
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
Wrist	☐	☐	AP, LAT
Hand	☐	☐	AP, LAT

Relevant History:
Osteoarthritis

Please Print Physician Name:

Physician Fax:

Authorizing Physician Signature:

Physician billing number: