

**COMPLEX JOINT (RECONSTRUCTIVE) CLINIC REFERRAL**

Telephone: 604-875-4688  
 Fax Requisition: 604-875-4617

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

PLEASE PRINT CLEARLY  ALLERGIES (PLEASE LIST):

BILLABLE TO: <input type="checkbox"/> MSP <input type="checkbox"/> ICBC <input type="checkbox"/> WCB <input type="checkbox"/> PATIENT <input type="checkbox"/> 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	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE PREGNANT: <input type="checkbox"/> YES <input type="checkbox"/> NO	
EMAIL:		FAX#:
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