Vancouver CoastalHealth

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

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

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: ☐ 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 ☐ MALE ☐ FEMALE 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 AN XRAY REPORT TAKEN IN THE LAST 12 MONTHS. REFERRALS ARE NOT ENTERED WITHOUT THESE 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