

OUTPATIENT REHAB REFERRAL FORM Hip/Knee/Shoulder Joint Replacement/Revision

This Outpatient Rehab Referral Form is for **scheduling post-surgery outpatient rehab for hip, knee and shoulder replacement or revision.**

- It may be submitted pre-operatively or post-operatively to only one organization for outpatient rehab.
- This pre-op referral form is not to be used for scheduling pre-surgery education or pre-surgery rehab.
- Not all outpatient rehab programs accept referrals pre-operatively. Please refer to the GTA Rehab Network website (Tools for Professionals, [Referral Forms](#) section) for a listing of programs that accepts external referrals pre-op.

Required for Pre-Operative Referral Process:

Outpatient Rehab to:	<ol style="list-style-type: none"> 1. Contact patient within 4 business days of receipt of referral, and provide an appointment date to patient. 2. Notify Acute Care within 4 business days if date of 1st outpatient rehab appointment is beyond the requested timeframe of referral.
Acute Care to:	<ol style="list-style-type: none"> 1. Notify outpatient rehab program if there is a change in surgery date or care plan.

Required Post-Operatively:

Acute Care to:	<ol style="list-style-type: none"> 1. Confirm outpatient rehab appointment with patient and/or outpatient rehab program. 2. Send a discharge summary note to outpatient rehab: The discharge summary note includes <ul style="list-style-type: none"> – relevant post-operative information (e.g., Physiotherapist and/or Physician note) – discharge date from acute care – treatment restrictions – a discharge medication list (preferred) – date of follow-up appointment with surgeon.
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Referral form is being submitted: <input type="checkbox"/> Pre-operatively <input type="checkbox"/> Post-operatively																												
Bundled care referral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Bradma/Addressograph <i>(Please verify patient telephone #)</i>																											
Date of Referral: D/____ M/____ Y/____																												
Organization: _____																												
Referral Contact Name: _____ Position: _____ Phone or Pager: () _____																												
Alternate Patient Contact: <i>(if required & authorized by patient)</i> Name: _____ Phone: () _____ Relationship: _____																												
Patient is being referred to outpatient rehab for:																												
	<table border="0" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align:center;">Knee replacement</td> <td style="text-align:center;">Revision of knee implant</td> <td style="text-align:center;">Hip replacement</td> <td style="text-align:center;">Revision of hip implant</td> <td style="text-align:center;">Shoulder replacement (total)</td> <td style="text-align:center;">Shoulder replacement (hemi)</td> <td style="text-align:center;">Shoulder replacement (reverse)</td> <td style="text-align:center;">Revision of shoulder implant</td> </tr> <tr> <td style="text-align:left;">Right</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align:left;">Left</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table>		Knee replacement	Revision of knee implant	Hip replacement	Revision of hip implant	Shoulder replacement (total)	Shoulder replacement (hemi)	Shoulder replacement (reverse)	Revision of shoulder implant	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Knee replacement	Revision of knee implant	Hip replacement	Revision of hip implant	Shoulder replacement (total)	Shoulder replacement (hemi)	Shoulder replacement (reverse)	Revision of shoulder implant																				
Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Other: <i>(e.g., additional procedures; resurfacing)</i> _____																												
Requested time frame for 1st outpatient rehab appointment post discharge:																												
Hip	<input type="checkbox"/> 2-3 weeks <input type="checkbox"/> 4-5 weeks <input type="checkbox"/> 6-8 weeks <input type="checkbox"/> Other _____																											
Knee	<input type="checkbox"/> within 7 days <input type="checkbox"/> Other _____																											
Shoulder	<input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks <input type="checkbox"/> 3-4 weeks <input type="checkbox"/> Other _____																											
Scheduled Date of Surgery: D/____ M/____ Y/____ <input type="checkbox"/> Date unknown																												
Anticipated Date of Acute Care Discharge: D/____ M/____ Y/____ <input type="checkbox"/> Date unknown																												
Patient consents to virtual care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown _____																												
Treatment Restrictions: <i>(if available at the time of referral)</i>																												
<input type="checkbox"/> No restrictions <input type="checkbox"/> Surgeon's instructions or post-operative protocol <i>(attached)</i> _____																												
<input type="checkbox"/> Weight Bearing _____																												
<input type="checkbox"/> ROM _____																												
<input type="checkbox"/> No active hip abduction x ____ weeks (<input type="checkbox"/> supine <input type="checkbox"/> sitting <input type="checkbox"/> standing) _____ <input type="checkbox"/> Hip precautions x ____ weeks																												
<input type="checkbox"/> Other <i>(please specify):</i> _____																												
Primary Diagnosis: <input type="checkbox"/> Osteoarthritis (<input type="checkbox"/> right <input type="checkbox"/> left) <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Avascular necrosis <input type="checkbox"/> Rotator cuff tear <input type="checkbox"/> Other <i>(specify):</i> _____	Secondary Diagnoses: <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiac <i>(specify in Other)</i> <input type="checkbox"/> Respiratory <i>(specify in Other)</i> <input type="checkbox"/> Other <i>(specify):</i> _____																											
Allergies: <input type="checkbox"/> None <input type="checkbox"/> Yes <i>(specify in Other)</i> <input type="checkbox"/> Latex <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	Bariatric? (>350 lbs.): <input type="checkbox"/> Yes <input type="checkbox"/> No																											
Transportation Plan to Outpatient Rehab:* <input type="checkbox"/> Family to drive <input type="checkbox"/> Other <i>(describe):</i> _____	Language spoken: <i>(if not English)</i> _____ Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																											
Attending Surgeon's Name: _____ Phone: () _____ Fax: () _____																												
Surgeon has authorized this outpatient rehab referral for this patient. <input type="checkbox"/> Yes _____																												
Family Physician's Name: _____ Phone: () _____ Fax: () _____																												