

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:

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| 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:

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| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Bundled care referral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Acute care surgical site: _____ <i>(if not the same as referral organization)</i> | Bradma/Addressograph <i>(Please verify patient telephone #)</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Referral: D/____ M/____ Y/____ Referral 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 style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:10%;">Knee replacement</th> <th style="width:10%;">Revision of knee implant</th> <th style="width:10%;">Hip replacement</th> <th style="width:10%;">Revision of hip implant</th> <th style="width:10%;">Shoulder replacement (total)</th> <th style="width:10%;">Shoulder replacement (hemi)</th> <th style="width:10%;">Shoulder replacement (reverse)</th> <th style="width:10%;">Revision of shoulder implant</th> </tr> </thead> <tbody> <tr> <td>Right</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Left</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> Other: <i>(e.g., additional procedures; resurfacing)</i> _____ | | | 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"/> | | | | | | | | | | | | | | | | | | | | |
| Requested time frame for 1st outpatient rehab appointment post discharge: <table style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tbody> <tr> <td style="width:15%;">Hip</td> <td style="width:15%;"><input type="checkbox"/> 2-3 weeks</td> <td style="width:15%;"><input type="checkbox"/> 4-5 weeks</td> <td style="width:15%;"><input type="checkbox"/> 6-8 weeks</td> <td style="width:15%;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td>Knee</td> <td><input type="checkbox"/> within 7 days</td> <td colspan="3"><input type="checkbox"/> Other _____</td> </tr> <tr> <td>Shoulder</td> <td><input type="checkbox"/> 1 week</td> <td><input type="checkbox"/> 2 weeks</td> <td><input type="checkbox"/> 3-4 weeks</td> <td><input type="checkbox"/> Other _____</td> </tr> </tbody> </table> | | 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 _____ | | | | | | | | | | | | |
| 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 _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Transportation Plan to Outpatient Rehab:* <input type="checkbox"/> Family to drive <input type="checkbox"/> Other <i>(describe):</i> _____ | Bariatric? (>350 lbs.): <input type="checkbox"/> Yes <input type="checkbox"/> No 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: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |