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:	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:	1. Notify outpatient rehab program if there is a change in surgery date or care plan.

Required Post-Operatively:

Acute Care to:	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 – 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.

GTA REHAB Network

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Please complete all applicable information

Referral form is being submitted: ❑ Pre-operatively ❑ Post-operatively

Bundled care referral? ❑ Yes ❑ No ❑ Unknown

Acute care surgical site: _____
(if not the same as referral organization)

Date of Referral: D/_____ M/_____ Y/_____

Referral Organization: _____

Referral Contact Name: _____

Position: _____

Phone or Pager: ( ) _____

Alternate Patient Contact: *(if required & authorized by patient)*

Name: _____

Phone: ( ) _____ Relationship:_____

Bradma/Addressograph *(Please verify patient telephone #)*

Patient is being referred to outpatient rehab for:

	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	❑	❑	❑	❑	❑	❑	❑	❑
Left	❑	❑	❑	❑	❑	❑	❑	❑

Other: *(e.g., additional procedures; resurfacing)*_____

Requested time frame for 1st outpatient rehab appointment post discharge:

Hip	❑ 2-3 weeks	❑ 4-5 weeks	❑ 6-8 weeks	❑ Other _____
Knee	❑ within 7 days	❑ Other _____		
Shoulder	❑ 1 week	❑ 2 weeks	❑ 3-4 weeks	❑ Other _____

Scheduled Date of Surgery:

D/_____ M/_____ Y/_____ ❑ Date unknown

Anticipated Date of Acute Care Discharge:

D/_____ M/_____ Y/_____ ❑ Date unknown

Patient consents to virtual care? ❑ Yes ❑ No ❑ Unknown _____

Treatment Restrictions: *(if available at the time of referral)*

❑ No restrictions ❑ Surgeon's instructions or post-operative protocol *(attached)* _____

❑ Weight Bearing _____

❑ ROM _____

❑ No active hip abduction x ___ weeks (❑ supine ❑ sitting ❑ standing) _____ ❑ Hip precautions x___ weeks

❑ Other *(please specify)*:_____

Primary Diagnosis:

❑ Osteoarthritis (❑ right ❑ left) ❑ Rheumatoid arthritis

❑ Avascular necrosis ❑ Rotator cuff tear

❑ Other *(specify)*: _____

Allergies: ❑ None ❑ Yes *(specify in Other)* ❑ Latex

❑ Unknown ❑ Other_____

Transportation Plan to Outpatient Rehab:* ❑ Family to drive

❑ Other *(describe)*:_____

Secondary Diagnoses:

❑ Diabetes Mellitus ❑ Hypertension

❑ Cardiac *(specify in Other)* ❑ Respiratory *(specify in Other)*

❑ Other *(specify)*: _____

_____

Bariatric? (>350 lbs.): ❑ Yes ❑ No

Language spoken: *(if not English)*_____

Interpreter required? ❑ Yes ❑ No ❑ Unknown

Family Physician's Name: _____ Phone: ( ) _____ Fax: ( ) _____

Attending Surgeon's Name:_____ Surgeon has authorized this referral for this patient. ❑ Yes

Phone: ( ) _____ Fax: ( ) _____ _____