

**Elective Hip and Knee Surgery - Replacements and Revisions**

The information contained herein is confidential. No unauthorized person will have access to the information without the consent of the patient/client or substitute decision-maker.

**Patient:** Last name: \_\_\_\_\_ First name: \_\_\_\_\_

**Health Card:** Number: \_\_\_\_\_ Version: \_\_\_\_\_ **Date of Birth:** Y/ \_\_\_ M/ \_\_\_ D/ \_\_\_

**Gender:**  Male  Female **Height:** \_\_\_\_\_  Unknown **Weight >250lb/113 kg:**  Yes  No  Unknown

**Address:** \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

**Home Phone Number:** ( ) \_\_\_\_\_ **Accommodation Requested:**  Standard  Semi-Private  Private

**Insurance Company:** \_\_\_\_\_ **Policy Certificate/group #:** \_\_\_\_\_

**Next of Kin/Emergency Contact:** Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

	Hip Replacement	Knee Replacement	Revision of Hip Implant	Revision of Knee Implant	Pin and Plate	Hemiarthroplasty
Right	<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"/>
Other:	_____					

**Primary Diagnosis:**  
 Unknown  Osteoarthritis (right)  Osteoarthritis (left)  AVN  RA  Other: \_\_\_\_\_

**Secondary Diagnoses (check all that apply)**  
 Unknown  
 Stroke/Acquired Brain Injury  Cardiac (specify) \_\_\_\_\_  
 Diabetes Milletus  Respiratory (specify) \_\_\_\_\_  
 Hypertension  Other (specify) \_\_\_\_\_

**Language spoken (if not English):** \_\_\_\_\_ **Interpreter required:**  Yes  No  Unknown

**Living Setting:**  
 Prehospital:  home  community  facility **Have discharge plans been discussed?**  Yes  No  
 Discharge:  home  community  facility

**Past and relevant history:**  
 Psychiatric:  Unknown  No  Yes (specify) \_\_\_\_\_  
 Medical:  Unknown  No  Yes (specify) \_\_\_\_\_  
 Surgical:  Unknown  No  Yes (specify) \_\_\_\_\_ Y/ \_\_\_ M/ \_\_\_ D/ \_\_\_

**Other Notes:** \_\_\_\_\_

**Date of Surgery:** Y/ \_\_\_ M/ \_\_\_ D/ \_\_\_  Date Unknown

**Date of Referral:** Y/ \_\_\_ M/ \_\_\_ D/ \_\_\_  Date Unknown

**Date Ready for Rehab/Self-Care:** Y/ \_\_\_ M/ \_\_\_ D/ \_\_\_  Date Unknown

**Physician/specialists involved in care of patient:**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Contact person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Position: \_\_\_\_\_ Pager: ( ) \_\_\_\_\_