UNIVERSITY OF ALBERTA
GLEN SATHER SPORTS MEDICINE CLINIC

Comprehensive Osteoarthritis Management, Education & Treatment Clinic

Please complete and return this form by fax to 780-407-5667

Referral Date:

Referring Physician Information:

Name: _____
Specialty: _____
Address: _____
Phone: _____
Fax: _____
Signature: _____
Family Physician Information (if different):
Name: _____
Phone: _____

Patient Information:

Name: _____
Address: _____
Date of Birth: _____
Health Card #: _____
Patient Gender: ☐ Male ☐ Female
Occupation: _____
Phone (Home): _____
Phone (Cell): _____
Email: _____

Reason for Referral/ Affected Joints: (check all that apply):

☐ Hip Right/Left ☐ Shoulder Right/Left
☐ Knee Right/ Left ☐ Ankle Right/Left

PLEASE ATTACH EXISTING X-RAY REPORTS OF THE AFFECTED JOINT

If no X-ray is available within the last 6 months, we recommend the following views: Knee: AP weight bearing, lateral of knee flexed at 30, skyline | Hip: AP pelvis, AP and lateral of affected hip

CURRENT SYMPTOMS (check all that apply)

☐ Locking

☐ Instability/giving way

☐Pain with activity:

☐Mild ☐Moderate ☐ Severe

☐ Pain at rest/night:

☐Mild ☐Moderate ☐ Severe

☐ Other:
_____

TREATMENTS TO DATE (check all that apply)

☐ Analgesics
☐ Non-steroidal anti-inflammatory drugs
☐ Injections: O Steroid
O Viscosupplement
☐ Hyaluronic Acid
☐ Platelet Rich Plasma
☐ Stem Cells
☐ Physiotherapy
☐ Exercise/weight loss
☐ Tylenol
☐ Bracing/ Orthotics
☐ Other: _____

EFFECTS: (Please Circle)

Good Relief

Moderate Relief

No Relief

Not Tried

Previous Surgery History: (Please include dates):

_____

CURRENT MEDICATIONS: (please list or attach medication profile):

_____

Past Medical History:

_____

_____

_____