December 19, 2019 Sent by E-Mail

Divisions of Family Practice
Physician Leads and Executive Directors

Dear Divisions of Family Practice Leaders:

Re: Access to Surgical Services

You may be aware that one of the Ministry of Health and Fraser Health priority areas is to improve access to surgical services for the populations we serve. To that end, the Ministry of health has asked health authorities to perform more surgeries in areas with long wait times, starting with hip and knee surgeries and incrementally tackling other surgeries with long wait lists.

We have had success with some of our communities within Fraser Health creating Surgical Services Programs (SSP) for Hip and Knee Arthroplasty patients. This includes a central intake and single point of access for health care providers, patients and families. It also includes receiving referrals through a central intake office and assigning first available, appropriate surgeon or surgeon of patient's choice. Currently we have central intake models operating in Burnaby, Ridge Meadows and Chilliwack. We hope to have central intake operational in additional communities by end of fiscal year (March 31, 2020).

The following are the recent average wait times in each of our Fraser Health communities for your reference. These wait times reflect the day the OR booking form is received by Fraser Health from the surgeons office, to the time of the patients surgical date.

Fraser Health Hospital	# Weeks Wait Time Hip/Knee Arthroplasty Surgery
Ridge Meadows Hospital	12
Burnaby Hospital	13
Chilliwack General Hospital	14
Langley Memorial Hospital	26
Abbotsford Regional Hospital	28
Peace Arch Hospital	30
Surrey Memorial Hospital	39

We hope that you may find this information useful as you triage your patients who require hip or knee arthroplasty surgery. Attached please find central intake referral forms for Ridge Meadows, Burnaby and Chilliwack. Should you have any questions, please contact Glenn Weigel, Director of Surgical Information Systems glenn.weigel@fraserhealth.ca

Sincerely,

Laurie Leith
Vice President, Regional Hospitals and Health Services

Attachments

Fraser Health Authority
Corporate Office

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Burnaby Hospital
Hip & Knee Arthroplasty
Centre Referral

Patient Name **M F DOB**

Care Card #

Address

Patient Phone Home	**Cell**	**Work**	**Speaks:** ☐ English ☐ Other:
Referring Practitioner Name:		**Phone:**	**FAX**

COMPLETE ALL RELEVANT FIELDS. ATTACH MEDICAL HISTORY/ MEDICATION LIST.
FAX TO 412-419-1418
INCOMPLETE REFERRAL WILL NOT BE PROCESSED.

Reason for referral:

☐ First available surgeon (recommended). Or ☐ Specify surgeon:_____

Affected joint (s): Knee: ☐ Right ☐ Left ☐ Bilateral **Hip:** ☐ Right ☐ Left ☐ Bilateral

***Attach X-rays as specified of the affected joint (s) (done within 3 months) ***

☐ Knee: 1. **Weight bearing** AP of both knees 2. Lateral knee of affected side 3. Skyline of affected side 4. Notch

☐ Hip: 1. AP Pelvis including proximal 1/3 of femurs 2. True lateral of affected hip

Pain with walking: ☐ None/Mild ☐ Moderate ☐ Severe

Loss of flexion, extension or joint stability
☐ None/Mild ☐ Moderate ☐ Severe

Walking tolerance <u>without</u> significant pain:
- ☐ Over 5 blocks
- ☐ 1 to 5 blocks
- ☐ Less than 1 block
- ☐ Household

Mobility aids used: ☐ Cane ☐ Crutches ☐ Walker ☐wheel chair.

☐ **Pain at rest (sitting, lying down, sleeping).**
How many nights a week is sleep disturbed? _____

Treatments Trialled
☐ Physio therapy
☐ Specialized exercise
☐ Joint injections.
Other:

Analgesics:
☐ PRN Opioids
☐ Scheduled Opioids

BMI _____ **Medical concerns** ☐ None ☐ Mild or past significant problem
☐ Constant significant, difficult to control. **Mental health:** ☐ Active Depression ☐ **Other comments**:

Signature. Referring Practitioner_____ Date: DD/MM/YY _____

For Burnaby Hip/Knee Centre USE ONLY

☐ * **Requires urgent** surgeon consult:

	Date	Time	Initials
☐ Received referral from Referring Practitioner (RP)			
☐ Surgeon appointment date _____Patient notified.			
☐ If surgeon specified, patient & RP notified of this consult date & first available date			
☐ Not a surgical candidate. Care plan to patient. Letter/Care plan to RP			

Chilliwack General Hospital Hip & Knee Arthroplasty Clinic Referral

fraserhealth

Patient Name **M F DOB**

Care Card #

Address

Patient Phone Home	**Cell**	**Work**	**Speaks:** ☐ English ☐ Other:
Referring Practitioner Name:		**Phone:**	**FAX:**

COMPLETE ALL RELEVANT FIELDS. ATTACH X-RAYS, MEDICAL HISTORY and MEDICATION LIST. INCOMPLETE REFERRALS WILL BE RETURNED. FAX TO 604-702-2877

Reason for referral:

- 1st Joint: Patient will be assigned to first available surgeon
- 2nd Joint only: Option ☐ Specify surgeon: _____

Affected Joint(s): KNEE: ☐ Right ☐ Left ☐ Bilateral HIP: ☐ Right ☐ Left ☐ Bilateral

Attach X-rays as specified of the affected joint(s) (done within 3 months) ☐ Available on PACS

☐ KNEE: 1. Weight bearing AP of both knees 2. Lateral bent knee of affected side 3. Skyline of affected side

☐ HIP: 1. AP Pelvis including proximal 1/3 of femurs 2. True lateral of affected hip

Pain with walking:
☐ None/Mild ☐ Moderate ☐ Severe

Loss of flexion, extension or joint stability
☐ None/Mild ☐ Moderate ☐ Severe

Walking tolerance without significant pain:
☐ Over 5 blocks
☐ 1 to 5 blocks
☐ Less than 1 block
☐ Household

Mobility aids used:
☐ Cane ☐ Crutches ☐ Walker ☐Wheelchair

☐ ***Unable to work, care for others or requires assistance with daily living related to affected joint.**

☐ **Pain at rest (sitting, lying down, sleeping).**
How many nights a week is sleep disturbed? _____

☐* **Has both ongoing pain with motion and at rest**

Treatments Trialled
☐ Physio therapy
☐ Specialized exercise
☐ Joint injections.
Other:

Analgesics:
☐ PRN Tylenol/NSAID
☐ Scheduled Tylenol /NSAID
☐ PRN Opioids
☐ Scheduled Opioids

☐ Concerns regarding an insitu arthroplasty. Specify:

Height____Weight_____BMI_____
Medical Concerns: ☐ None ☐ Mild or past significant problem ☐ Constant significant, difficult to control
Mental health: ☐ Active Depression ☐ **Other comments:**
☐ Hgb A1C ☐ Smoker

Signature of Referring Practitioner: _____ Date: DD/MM/YY _____

For Chilliwack General Hip/Knee Centre USE ONLY

☐ * **Requires urgent** surgeon consult:

	Date	Time	Initials
☐ Received referral from Referring Practitioner (RP)			
☐ Surgeon appointment date_____Patient notified.			
☐ If surgeon specified, patient & RP notified of this consult date & first available date			
☐ Not a surgical candidate. Care plan to patient. Letter/Care plan to RP			

Ridge Meadows Hospital
Hip & Knee Replacement
Clinic Referral

Patient Name **M F DOB**

Care Card #

Address

Patient Phone Home	**Cell**	**Work**	**Speaks:** ☐ English ☐ Other:
Referring Practitioner Name:		**Phone:**	**FAX**

COMPLETE ALL RELEVANT FIELDS. ATTACH MEDICAL HISTORY/ MEDICATION LIST. FAX TO 604-476-7807
INCOMPLETE REFERRAL WILL NOT BE PROCESSED.

Reason for referral:

☐ First available surgeon (recommended). Or ☐ Specify surgeon:_____

Affected joint (s): Knee: ☐ Right ☐ Left ☐ Bilateral **Hip:** ☐ Right ☐ Left ☐ Bilateral

***Attach X-rays as specified of the affected joint (s) (done within 3 months) ***

☐ Knee: 1. **Weight bearing** AP of both knees 2. Lateral knee of affected side 3. Skyline of affected side 4. Notch

☐ Hip: 1. AP Pelvis including proximal 1/3 of femurs 2. True lateral of affected hip

Pain with walking: ☐ None/Mild ☐ Moderate ☐ Severe

Loss of flexion, extension or joint stability
☐ None/Mild ☐ Moderate ☐ Severe

Walking tolerance <u>without</u> significant pain:
- ☐ Over 5 blocks
- ☐ 1 to 5 blocks
- ☐ Less than 1 block
- ☐ Household

Mobility aids used: ☐ Cane ☐ Crutches ☐ Walker ☐wheel chair.

☐ **Pain at rest (sitting, lying down, sleeping).**
How many nights a week is sleep disturbed? _____

Treatments Trialled
☐ Physio therapy
☐ Specialized exercise
☐ Joint injections.
Other:

Analgesics:
☐ PRN Opioids
☐ Scheduled Opioids

BMI _____ **Medical concerns** ☐ None ☐ Mild or past significant problem
☐ Constant significant, difficult to control. **Mental health:** ☐ Active Depression ☐ **Other comments**:
☐ Diabetic HbA1C

Signature. Referring Practitioner_____ Date: DD/MM/YY _____

For Ridge Meadows Hip/Knee Clinic USE ONLY

☐ * **Requires urgent** surgeon consult:

	Date	Time	Initials
☐ Received referral from Referring Practitioner (RP)			
☐ Surgeon appointment date _____Patient notified.			
☐ If surgeon specified, patient & RP notified of this consult date & first available date			
☐ Not a surgical candidate. Care plan to patient. Letter/Care plan to RP			