Vancouver Coastal Health
Promoting wellness. Ensuring care.

OASIS Program Referral Form

OASIS OsteoArthritis Service Integration System

Education Requests - Complete Sections 1 & 2.
Assessment Requests - Complete Sections 1 & 3.

Please assist us in providing service to your patient by completing all relevant information.

Section 1: PATIENT DEMOGRAPHICS

This section must be completed for all requests.

Patient Name: _____
Surname First Name Initial

Phone (Home):

Address:

Phone (Work):

City: Postal Code:

Phone (Cell):

PHN: Birthdate: DD MM YYYY Age: Sex:

Does patient speak/understand English? ☐ Yes ☐ No If no, language spoken: _____

If no, please provide an alternate contact (name/number):

Referring Provider: MSP ID: Phone: Fax:

Primary Care Physician: (if different from above) MSP ID: Phone: Fax:

AFFECTED JOINTS:

☐ L. Hip ☐ L. Knee ☐ L. Foot ☐ L. Ankle ☐ L. Hand ☐ L. Wrist ☐ Other: _____

☐ R. Hip ☐ R. Knee ☐ R. Foot ☐ R. Ankle ☐ R. Hand ☐ R. Wrist

Section 2: EDUCATION

Please Note: Education is included during an assessment

☐ Education Session
☐ Written Materials

Topics

☐ Intro to OA/Joint Protection
☐ Pain Management
☐ Nutrition/Supplements
☐ Exercise and OA
☐ Weight Management
☐ Other (specify) _____

Section 3: ASSESSMENT APPOINTMENT

A

ASSESSMENT TYPE

☐ Assessment – Conservative Management
☐ Assessment – Surgical or Possible Surgery
☐ Assessment – Surgical Urgent

(Please attach any consult reports to this referral)

Select consult surgeon options

1st Available Surgeon in:

☐ VCH Region ☐ Richmond
☐ Vancouver ☐ North Shore

----- or -----

Name of Preferred Surgeon(s):

_____

B

CURRENT REFERRALS

a) Has the patient already been referred for a surgical consult?

☐ Yes ☐ No If yes, surgeon: _____ Joint: _____

b) If yes to "a", has surgical consult taken place? ☐ Yes ☐ No

c) If yes to "b", is client a surgical candidate? ☐ Yes ☐ No

C

X-RAY REQUIRED for assessment. See reverse side of the form for accepted X-ray views.

Are current x-rays (within 1 year) available?

☐ Yes – Please attach X-Ray Report with this referral. Indicate X-Ray Facility: _____

☐ No – If no, OASIS will initiate an X-Ray Requisition Form for the PCP to sign

D

ADDITIONAL PATIENT INFORMATION

_____

_____

E

COORDINATION OF CARE
(To be completed by PCP only)

Please note: OASIS will coordinate assessment recommendations and forward a copy of the patient's Action Plan and relevant documents to the PCP unless you indicate otherwise.

☐ PCP to initiate and coordinate all the recommendations on the OASIS Action Plan with the patient

Physician/Referring Provider Signature: _____ Date: DD MM YYYY

OASIS Program Referral Form Instructions

DO NOT FAX THIS SIDE when referring patients to OASIS. This is an Informational page for your use.
Please Note: Referrals can not be processed unless all information is complete.

Section 1: PATIENT DEMOGRAPHICS

Complete patient demographices and referring physician/provider information:
AFFECTED JOINTS: Indicate all joints affected by OA.

Section 2: EDUCATION

Your patient does not need to have an assessment with OASIS to receive information. You may refer them to OASIS for Education Only by completing sections 1 and 2, signing form and faxing it to OASIS.

Section 3: ASSESSMENT APPOINTMENT

To request an assessment appointment for your patient complete sections 1 and 3 of the Physician Referral Form, sign it and fax the form to the appropriate OASIS clinic. You may also complete section 2 if you would like to specify information you would like your patient to receive.

Items of Note when completing sub-sections A, B, C, D, and E:

- Indicate the affected joint(s)
- Specify assessment type
- If surgical or possible surgery, please indicate the consultation option: 1st available or preferred surgeon(s)
- Indicate if the patient has already been referred to a surgeon
- An x-ray is required during the assessment appointment.
  - If your patient has had an x-ray in the past year, indicate the facility where the x-ray is available. OASIS will arrange to have the x-ray forwarded to the clinic for the scheduled appointment.
  - If your patient does NOT have a recent x-ray (within one year), indicate that a new x-ray is required. OASIS will assist by generating an X-ray Requisition for you to sign and give to your patient.
- Please indicate any additional pertinent information OASIS should know about when scheduling the assessment appointment
- Specify who will coordinate care (PCP only). PCP will be notified if other healthcare provider is referring patient and will be asked at that time if they prefer to coordinate care.
- Sign the referral form

X-RAY INFORMATION

OASIS requires a recent (within 1 year) x-ray and x-ray report during the assessment appointment. The following are the appropriate x-ray views identified by surgeons.

Hip: Standing AP (weight bearing) of pelvis centered low to include prox. 1/3 femur & true lateral of hip

Knee: Standing AP (weight bearing), LAT, Skyline Patella of affected side

Hand: Posterior-anterior

Ankle: Standing AP (weight bearing), lateral, mortise

Foot: Standing AP (weight bearing), lateral, oblique

OASIS Clinics - Contact Information

Choose which Clinic your patient wants to attend. If the chosen clinic is not available within set time frame patient will be given the option to attend an alternate clinic.

Vancouver Clinic	**Fax: 604.875.8294**	**Phone: 604.875.4544**
Richmond Clinic	**Fax: 604.675.3943**	**Phone: 604.675.3944**
Coastal (North Shore) Clinic	**Fax: 604.904.6170**	**Phone: 604.904.6177**

*** New Referral Forms available on the OASIS website at http://oasis.vch.ca or by calling 604-875-4257.**

For more information, please call the OASIS Regional Office at 604-875-4257 or visit http://oasis.vch.ca