



GREY BRUCE HEALTH NETWORK

**TOTAL HIP REPLACEMENT
ASSESSMENT FORM FOR THERAPY
REFERRAL**

PATIENT ID

This is a guideline only, and is not a substitute for clinical judgement.

Instructions:

- 1) If patient meets most criteria, most likely requires pre-op home O/T assessment.
- 2) If patient meets 2 or more criteria, most likely requires a post-op CCAC P/T referral, as this indicates the patient is not a candidate for outpatient services.

<input type="checkbox"/> Lack of support at home.
<input type="checkbox"/> Safety/Environmental barriers. (i.e. Stairs with no railings, weight bearing restrictions, visual impairments)
<input type="checkbox"/> Suspected cognitive issues.
<input type="checkbox"/> No evidence of equipment in place, inability to acquire pre-operatively.
<input type="checkbox"/> Use of CCAC services within 3 months.
<input type="checkbox"/> Unable to access outpatient physio services.
<input type="checkbox"/> Patient having difficulty with self-care or independent functioning preoperatively
<input type="checkbox"/> Additional Comments (i.e. Involvement in The Arthritis Society):

Referral for CCAC: Pre-Op: O/T Post-Op: P/T O/T Other _____

CCAC I & R (519) 371-2112 fax (519) 371-5612

Referral for Outpatient Physiotherapy: Site: _____

Central Scheduling Owen Sound (519) 376-2648 or 1-888-525-0553 fax (519) 376-3952

Fire & Concession # _____

Surgery Date: _____ Surgeon: _____ Surgery: _____

Verbal consent obtained to share information with CCAC Yes No

Signature: _____