Vancouver Coastal Health
Promoting wellness. Ensuring care.

Referral for Treatment

MARY PACK ARTHRITIS PROGRAM VANCOUVER

Mary Pack Arthritis Program
895 10th Avenue W
Vancouver, BC V5Z 1L7
Phone: 604-875-4040
Fax: 604-875-4321
Rev. 10/2017

Name: _____ Gender: ❑ M ❑ F
Surname First

Address: _____
Street City Postal Code

DOB: _____ Home Phone: _____ Alternate Number: _____
(MM / DD / YYYY)

PHN: _____ Alternate Contact: _____ Phone: _____

Family Doctor: _____ Phone: _____ Fax: _____

Referring Doctor: _____ Phone: _____ Fax: _____

Signature: _____ Dr. #: _____ Date: _____

Referring Dr.'s office stamp

Arthritis Dx requiring Tx: _____ **Diagnosed when?** ❑<1 year ❑>1 year

Joints affected: _____ **Impact on daily living**: ❑Mild ❑Moderate ❑Severe

Other Dx: _____ **Diagnosed when?** ❑<1 year ❑>1 year

Remarks / Contraindications: _____

_____

ADMISSION CRITERIA

1. Inflammatory rheumatic diseases
2. Post-operative arthroplasty (rheumatic disease as primary diagnosis)
3. Osteoarthritis – multiple joint

EXCLUSION CRITERIA

1. Osteoporosis not related to rheumatic disease
2. Fibromyalgia and/or chronic pain syndromes
3. Open ICBC or WorkSafeBC claim
4. Soft tissue conditions (e.g., tendonitis, bursitis, frozen shoulder)
5. Mechanical back pain (unless associated with degenerative/inflammatory arthritis)

►►RECENT LAB, X-RAY, AND/OR CONSULTS REQUIRED◄◄

Note: The Mary Pack Arthritis Program may forward patient referrals to other appropriate local services.

❑ Group education not appropriate
❑ Need for interpreter (Language: _____)

TREATMENT REQUESTED

(Referrals for rheumatologists should be sent to the private practice clinic of your choice)

MEDICAL CLINICS	PHYSIOTHERAPY	OCCUPATIONAL THERAPY	SOCIAL WORK	NURSING
Specialist referral only (*) ❑ Biologic Infusions* ❑ Lupus ❑ Oral Medicine* ❑ Orthopaedic* ❑ Outpatient Day* ❑ Psychiatry* ❑ Scleroderma ❑ Vasculitis ❑ Young Adult* ❑ Drug Monitoring*: _____	❑ Assessment & Tx **Programs** ❑ Post-op Hip L / R ❑ Post-op Knee L / R Surgery Date: _____ Facility: _____ Dx requiring surgery: _____	❑ Assessment & Tx ❑ Splinting ❑ Footwear /Orthotics ❑ Adaptive Equipment	❑ Counselling (mood, coping, finances, community resources)	❑ Education ❑ Self-Injection Teaching
		COMBINED PT/OT PROGRAMS		**EDUCATION**
		❑ Paediatric ❑ Post-op Hand L / R		❑ Patient Education Program

RECEIPT OF REFERRAL

❑ Your referral has been received.
We will contact your patient directly to make an appointment.

Date rec'd: _____

OFFICE USE ONLY

❑1 ❑2 ❑3 Chart #: _____

Ref #: _____