Vancouver CoastalHealth
Promoting wellness. Ensuring care.

External 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. 11/2018

Name: ______________________________ (Surname) ______________________________ (First) Gender: ❑ M ❑ F

Address: ______________ (Street) ______________ (City) ______________ (Postal Code)

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

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	COMBINED PT/OT PROGRAMS
Specialist referral only (*) ❑ Biologic Infusions* ❑ Lupus ❑ Oral Medicine* ❑ Orthopaedic* ❑ Outpatient Day* ❑ Psychiatry* ❑ Scleroderma ❑ Vasculitis ❑ Young Adult* ❑ Pregnancy ❑ 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 **SOCIAL WORK** ❑ Counselling (mood, coping, finances, community resources)	❑ Post-op Hand L / R **EDUCATION** ❑ Patient Education Program **NURSING** ❑ Education

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 #: ____________