Return via Fax (07) 5506 7578

Date:

**Patient Information:**

Name:

DOB:

Phone:

Address:

GP:

**Referrers Details:**

Name:

Practice Name:

Phone:

Address:

**\*\*\*\* This service is for clients NOT on waiting list for joint replacement surgery \*\*\*\***

**History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area of Pain** | Left Knee Right Knee Left Hip Right Hip | | |
| **Pain over time** | Pain getting worse Pain getting better | | |
| **Ave Pain past week** | 1 2 3 4 5 6 7 8 9 10 | | |
| **Quality of Pain** | Throbbing/ Ache Radiating Dull Sharp    Catching/Locking Swelling Stiffness Instability | | |
| **Time frame of**  **Pain reporting** | Less than 3 mths | 6-12 mths | 2-5 years |
| 3-6 months | 12 months-2 years | More than 5 years |

|  |  |  |
| --- | --- | --- |
| **Pain History;** | **Y** | **N** |
| Do you experience pain/difficulty getting out of **chair** |  |  |
| Do you experience pain/difficulty getting out of **car** |  |  |
| Do you experience pain/difficulty whilst moving up or down **stairs** |  |  |
| Do you experience pain/difficulty at **night** |  |  |
| Do you experience **morning joint stiffness/pain** |  |  |

|  |  |  |
| --- | --- | --- |
| **Examination ;** | **Y** | **N** |
| Evidence of swelling |  |  |
| Tenderness over joint |  |  |
| Evidence of reduced ROM |  |  |
| Crepitus on movement |  |  |

|  |  |  |
| --- | --- | --- |
| **Investigation; (Note: X-ray required for referral to SOS Clinic)** | **Y** | **N** |
| Evidence of Joint space narrowing on X-ray |  |  |

|  |  |  |
| --- | --- | --- |
| **Comorbid medical conditions;** | **Y** | **N** |
| Cardiovascular disease |  |  |
| Neurological disorder |  |  |
| Diabetes |  |  |
| Depression/anxiety |  |  |
| Obese |  |  |
| Other |  |  |
| **Other findings on Examination;** | | |

\*\*\*\*\*\*\* Please attach current Patient Health Summary \*\*\*\*\*\*\*\*\*

Signature: Date: