OASIS Regional Education Program Referral Form

895 West 10th Avenue, Vancouver BC, V5Z 1L7

Tel: 604 875 4544 **Email:** oasis@vch.ca **Website:** oasis.vch.ca

SECTION 1: PATIENT DEMOGRAPHICS:

Surname: _____ **First Name:** _____ **Initial:** _____

Address: _____

City: _____ **Postal code:** _____

Phone (home): _____ **Phone (cell):** _____ **Email:** _____

PHN: _____ **Birthdate (d/m/y):** _____ **Age:** _____ **Gender:** _____

Does the client understand English: ☐ Yes ☐ No If no, language spoken: _____

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

Referring Provider: _____ **Tel:** _____ **Fax:** _____

PCP (If different): _____ **Tel:** _____ **Fax:** _____

Joints affected with arthritis:	**Hip**	☐ L	☐ R	**Shoulder**	☐ L	☐ R	**Spine** ☐
	Knee	☐ L	☐ R	**Elbow**	☐ L	☐ R	
	Foot/Ankle	☐ L	☐ R	**Wrist/Hand**	☐ L	☐ R	

SECTION 2: GROUP ARTHRITIS EDUCATION REQUIREMENTS:

Please tick CORE arthritis education topics required:

Arthritis/joint protection (joint specific)	☐	Pain Management	☐
Nutrition & Supplements	☐	Exercise	☐
Prehab for THA/TKA	☐	Pole-walking	☐

Further topics are available following attendance at the CORE education sessions.

Preferred group education type: In-person ☐ Online/virtual ☐ Both ☐

Referring Provider/ PCP Signature: _____ **Date:** dd/mm/yy

Provide referral form to patient, or
Fax completed form to 604 875 4321 if initial contact from OASIS is preferred.