

Date: [Insert Date]

To: [Referring Physician Name]

Address: [Clinic/Hospital Address]

RE: Joint Replacement Surgical Assessment

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Health Number: [ID Number]

Dear Dr. [Last Name],

I had the pleasure of seeing [Patient Name] in consultation today regarding the evaluation of their [Right/Left] [Hip/Knee/Shoulder] for potential joint replacement surgery.

History of Presenting Illness:

The patient reports a [Number]-year history of progressive pain and functional decline. Current symptoms include [stiffness, night pain, limited walking distance]. They have attempted conservative management including [physiotherapy, NSAIDs, injections, weight loss] with limited relief.

Physical Examination:

Examination of the [Joint] reveals [decreased range of motion, antalgic gait, crepitus, instability]. Neurovascular status of the distal limb remains intact.

Imaging Results:

Radiographs dated [Date] demonstrate [Grade of Osteoarthritis, joint space narrowing, osteophytes, subchondral sclerosis].

Assessment and Plan:

Based on the clinical and radiographic findings, the patient is a candidate for a Total [Joint] Arthroplasty. We have discussed the risks, benefits, and expected outcomes of the procedure.

Decision:

Patient has elected to proceed with surgery. (Waitlist time: approximately [Months])

Patient wishes to continue conservative management at this time.

Further medical clearance is required from [Specialty] regarding [Condition].

Thank you for involving me in the care of this patient. I will update you once a surgical date has been finalized.

Sincerely,

[Your Signature]

[Your Printed Name]

Orthopedic Surgeon

[Phone Number]

[Fax Number]