MAY 14, 2025

ENTER A REFERRAL FOR ORTHOPEDIC SERVICES

CENTRAL INTAKE



NOTE: Only orthopedic referrals for adult cases should be entered into Central Intake. *Emergency cases or those to be referred to the Janeway are NOT to be submitted using Central Intake.* Follow existing procedures or protocols for submitting these referrals.

- 1. Access Central Intake using **Healthe NL** or your **EMR**. *Refer to the user guide "Accessing the Central Intake Solution" for more information.*
- 2. Search for the patient you want to enter an orthopedic referral. The **Central Intake Referral** screen is displayed.
- Begin to complete the Orthopedic referral for the patient.
- 4. The Patient's Demographic Summary information displayed in this

Ξ	Central Intake • Refe	alth erral	Patient KROLLA(TM), ADRIA - (-	•			Referral Type Orthopaedics	Ruforral ci-0002790	Siatus Draft referral
Patient D	Demographics	Patient Dem	ographic Summary						
		Identifiers	Alternate Names	Sex / Gender	Date of Birth (Age)	Preferred Contact Method			
+ Patient S	Supplemental Information 🛕		KROLLA(TM), ADRIA (Legal)	Female	12-May-1959 (66 years)				
* Workflow	w History	Address		Phone	Email				
		GAPARTMENT # 201,TES	STDATA, NEW MELBOURNE, Newfoundland and	706 555 5555 (Client Registry	- Home)				
* Patient U	Unavailability	Labrador, Canada, NL (C	lient Registry - Postal)						
· Change 1	Tracker								
		Patient Supp	lemental Information						
		*Has the on call O	thopaedic specialist been contacted about t	his referral? 🔿 Yes 🛛 Ni	0				
						Close	PDF	s	ave
		Workflow							
						Su	bmit Ca	ancel - Draft Refer	ral (End)

section is populated from the client registry. You have the option to edit some of the patient's

demographic information; fields with a blue + or a Pencil icon can be updated. However, this information added will only be applicable for this current referral (and is not saved back to the Client Registry).

- 5. Enter the **Patient Supplemental Information** section and answer the question by checking the appropriate checkbox: *"Has the on call Orthopaedic specialist been contacted about this referral?"*
- 6. Follow the screen prompts to enter information for the referral.

ΓIΡ

Depending on how you answer a question or complete a field may expand a section of the referral that requires additional information to be entered.

TIP

An * indicates that the field is required, i.e., you must enter information, select from a dropdown list, or answer the question.

Patient Location and Appointment Location
 identify the patient's health zone and the specialist where the referral will be submitted. If
 Next Available is selected from the dropdown list, the patient's referral will be prioritized with
 a specialist who has availability

	*Zone				0
Patient home zone:	Central	× ~	Book with Specialist	× v	
		(6)		1	Patients are generally seen by orthopedic specialist in their home zone.
					Requests for specific specialists will result in longer wait times.



8. If you answer **Yes** to the **Appointment Location** question, you will be prompted to enter additional information to further explain the reasons and preferred zone to receive treatment.

Appointment Location		
Λ.	Please provide additional details (e.g. zone; reason)	
Is there a competing reason for the patient to be seen outside of the	eir home/designated zone (Optional) Yes No	
If "Ves' you must provide additional details		

 Complete the Clinical Information (Reason(s) for Referral and Potential Diagnosis) section – Identify the Problem and choose the option from the corresponding Type section dropdown list.

eason(s) for Referral and Potential Diagnosis	Peacon(c) for Poterral and Potential Diagnosis	Reason(s) for Referral and Potential Diagnosis
X A.	Poden Potential Diagnosis	Theater Type Theater Degrees
low	Knee X v X v	Ankylosing Spondylitis
selletin	Biateral	Avascular Neorosia
	Left	BoneUpint Intection
/www.	Rate	Workflow History Deletation (Aute)
house ory		Dislocation (Chronic)
pire		Status Faled Surgical Procedure
VistHand Dotters		Draft referral

- 10. Identify the **Potential Diagnosis** and choose from the corresponding options.
- 11. In some cases, you will be prompted with a question related to x-rays being completed. Answer the question appropriately by selecting either **Yes** or **No**. If No is selected, a message is displayed indicating the referral cannot proceed without first completing the necessary x-ray(s).



12. In the **Symptoms** section, you may select one or more symptoms that the patient is experiencing. Additional fields will be displayed which must be completed. Select the appropriate **Condition of Symptoms** and **Duration of Symptoms** from each of the dropdown lists.

* Symptoms	Difficulty sleeping Groit	n Pain 🗌 Instability 🗌 Lo	cking 🗌 Pain at rest	Pain with walking/activ	ity 🗌 Other	
Condition of Symptoms	× ^					
Stable	ptional)					
Worsening						
~						
Has an x-ray of the	nee (AP weight bearing; latera	al of knee) been completed v	ithin 6 months? 💿 ۱	les 🔿 No		
Has an x-ray of the	nee (AP weight bearing; latera	al of knee) been completed v	/ithin 6 months? () Y	/es 🔿 No		
Has an x-ray of the Symptoms	nee (AP weight bearing; latera	al of knee) been completed v Groin Pain 🗌 Instability	vithin 6 months?	r⁄es ◯ No Pain at rest 🗹 Pain wi	th walking/activity	Other
Has an x-ray of the Symptoms Condition of Symptoms	nee (AP weight bearing; latera	al of knee) been completed w Groin Pain 🗌 Instability	ithin 6 months?) ۱	Yes ○ No Pain at rest 🗹 Pain wi	th walking/activity	Other
Has an x-ray of the Symptoms Condition of Symptoms Vorsening	nee (AP weight bearing; latera	al of knee) been completed v Groin Pain Instability	ithin 6 months? ● ۱ Locking I	r⁄es ◯ No Pain at rest 🗹 Pain wi	th walking/activity 🗌 (Other
Has an x-ray of the Symptoms Condition of Symptoms Vorsening History of presentin	Difficulty sleeping	II of knee) been completed v Groin Pain 🔲 Instability	ithin 6 months?	r⁄es ◯ No Pain at rest 🗹 Pain wi	th walking/activity 🗌 (Other
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Has an x-ray of the Symptoms Condition of Symptoms Vorsening History of presentin	nee (AP weight bearing; latera Difficulty sleeping * Contain of Sympa * Contain of	II of knee) been completed v Groin Pain Instability	ithin 6 months?) الم	′es ○ No Pain at rest 🗹 Pain wi	th walking/activity 🗌 (Other
Has an x-ray of the Symptoms Condition of Symptoms Vorsening History of presentin	Innee (AP weight bearing; latera Difficulty sleeping * v illness (Opto Acute Onset 3-0 Months 6-12 Months	I of knee) been completed v Groin Pain Instability	ithin 6 months?) الم	res ○ No Pain at rest 🔽 Pain wi	th walking/activity 🗌 (Other



13. **[Optional]** Enter **History of presenting illness** that may provide more information to the Central Intake team and the specialist assigned to the case.

History of presenting illness (Optional)		
]

14. For two of the questions, if you respond Yes, you will be prompted to enter additional information:

*Have you completed a physical assessment of the patient?	○ Yes ● No
Please provide a reason	
*Has the patient been seen by an Orthopaedic specialist in the past?	Yes No Unknown Name
Please provide the specialist name	
*Does the patient have any mobility concerns?	🔿 Yes 💿 No
History of falls Mobility Aids Non-Ambulatory Rang	of motion restrictions 🗌 Other

15. [Optional] The next sections to be completed are Treatments to Date, Pertinent Past Medical History and Medications.

Treatment(s) to Date (Optional)
Injections Pain Medications Physiotherapy Previous Orthopaedic Surgery Other
Pertinent Past Medical History (Optional)
Pertinent Past Medical History (Optional)
Medications (Optional)
(Medications (Optional)

16. **[Optional]** Enter **Other Relevant Patient Information** that may provide more information to the Central Intake team and the specialist assigned to the case.





17. Verify your information as the referrer. You have the option to update your contact information and add new location by clicking on Manage Locations.

TIP

If a new address is entered, it will be **linked to this referral only**. Referrals entered for other patients, will not display the new address for the referring physician.

Referring Physician *Referring Provider eu-pr-clinc-pcp.mh	××				Manage Locations
Location					
Test3	× v				
*Phone	★ Fax	*Address line 1		City / Municipality	Province / State
2121212112111	2222233333	12 Water St	Address line 2	St John's	Newfoundland and Labr
Country	Postal / Zip Code	Email			

18. **[Optional]** Upload any additional files in the **Supporting Documents** section.

Supporting Documents							
Orthopaedic referral supporting documents							
	Filename	Document Type	Document Description				
•							

TIP

Verify the document you are uploading is the correct patient to match the referral. Currently, the document CANNOT be DELETED once uploaded. This functionality is planned for a future release.

19. Click Save. Clicking save does not submit the referral for processing. The referral is in

DRAFT form while the details are being entered.

- a. **Close** will exit you from the referral without saving.
- b. The **PDF** button appears after you click Save. The PDF version of the referral allows you to save a copy of the referral to your computer or to print a copy of the referral.

Referral still draft. Click "Submit" for Central Intake processing							
Close	PDF	Save					

TIP

Referrals in a DRAFT stage can only be viewed by the Primary Care Provider (PCP) who started the referral. **PCPs must complete the draft referral and SUBMIT!**

Central Intake staff will not be auditing referrals in DRAFT. For the referral to be processed, the PCP is responsible for completing the DRAFT referral. Click SUBMIT to move the referral to the next stage!

Workflow History

Status	Status Date	Status Updated By	Status Detail
Submitted Referral	14-May-2025	euprclincpcpmh	
Draft referral	14-May-2025	loisgibson	



20. Click **Submit**. This triggers the referral to enter the queue with Central Intake for the next stage of the referral process – triage and prioritization.





