



RHEUMATOLOGY REFERRAL FORM - Fax completed forms to: 613-738-8249

**\*\*Incomplete forms will be returned\*\***

**\*\*We do NOT accept referrals for:** \*Osteoarthritis \*Degenerative disc disease \*Chronic pain \*Fibromyalgia

**Patient Information or Label:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Health Card #: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Alt: \_\_\_\_\_

**Referring MD Information or Label:**

Referral Date: \_\_\_\_\_

Referring MD: \_\_\_\_\_

Billing #: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Reason for referral:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has this patient been previously assessed by a Rheumatologist? NO  YES  (attach latest report)

**Which condition do you suspect?** (Please attach corresponding investigations **WITH** the referral)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>INFLAMMATORY ARTHRITIS / POLYARTHRITIS</b></p> <p>CBC, ESR, CRP, creatinine, ALT/Alk Phos, albumin, RF, Anti CCP Xray of affected joints</p>	<p><b>CONNECTIVE TISSUE DISEASE</b></p> <p>CBC, ESR, CRP, creatinine, ALT/Alk Phos, albumin, Urinalysis, RF, ANA, anti-dsDNA, ENA profile, C3, C4</p>	<p><b>SPONDYLOARTHROPATHY</b></p> <p>CBC, ESR, CRP, creatinine, ALT/Alk Phos, albumin, Xray SI joints &amp; affected spine</p>	<p><b>MYOSITIS</b></p> <p>CBC, ESR, CRP, creatinine, ALT/Alk Phos, albumin, CK, ANA, ENA profile</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>POLYMYALGIA RHEUMATICA GIANT CELL ARTERITIS</b></p> <p>CBC, ESR, CRP, creatinine, ALT/Alk Phos, albumin, RF, CK</p>	<p><b>VASCULITIS</b></p> <p>CBC, CRP, creatinine, ALT/Alk Phos, albumin, Urinalysis, RF, ANA, ENA profile, C3, C4 ANCA, Hep B &amp; C Serology</p>	<p><b>GOUT</b></p> <p>CBC, ESR, CRP, creatinine, ALT/Alk Phos, albumin, Urate</p>	<p><b>OSTEOPOROSIS</b></p> <p>CBC, Creatinine, Bone Mineral Density</p>

**\*\*Please attach all relevant consults, imaging and bloodwork\*\***

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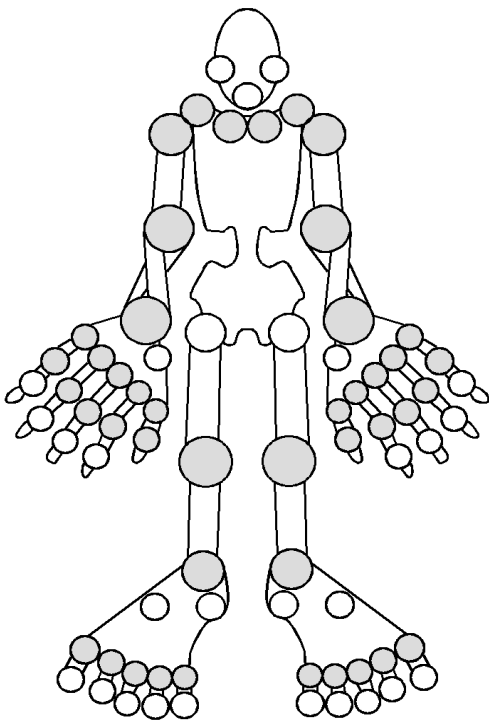
**How long has the patient had this problem?**

- < 6 months
- 6-12 months
- > 12 months (# of years \_\_\_\_\_)

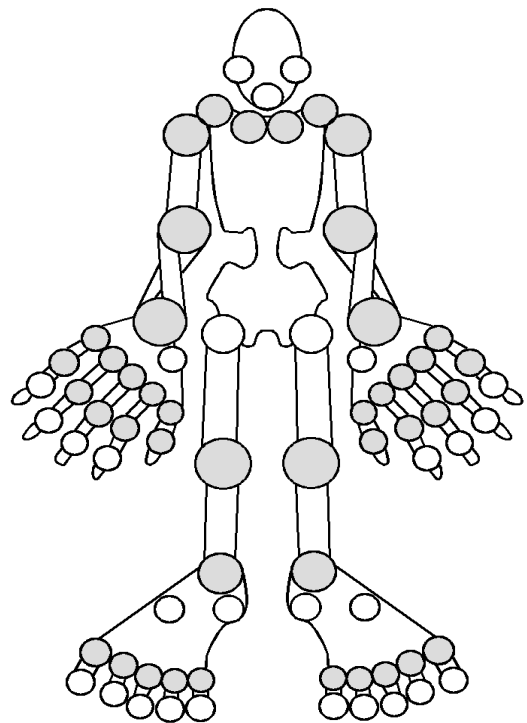
**Is there morning joint stiffness lasting:**

- > 1 hour
- < 1 hour

**Please fill the circles to indicate TENDER joints.**



**Please fill in the circles to indicate SWOLLEN joints.**



**Current Relevant Treatment(s) and effectiveness:**

- NSAIDS - Effective? \_\_\_\_\_
- Prednisone - Effective? \_\_\_\_\_
- Other \_\_\_\_\_

**The Arthritis Centre / Le Centre de l'arthrite**  
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