INVOLVED RHEUMATOLOGY

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PATIENT REFERRAL FORM

Referral Guidelines – Please Include

1. IMAGING REPORTS ATTACHED: X-RAY ☐ ☐ ULTRASOUND ☐ MRI

   Please include any X-RAYS FOR EROSIONS OR BONY PROLIFERATIVE CHANGES OR SACROILITIS OR SYNDESMOPHYTES

2. PREVIOUS ☐ MEDICAL CONSULTATIONS ☐ SURGICAL CONSULTATIONS

Provider Name and OHIP#:_____ Provider FAX#:_____

Provider E-mail: _____ Provider TEL#:_____

Patient Information

Patient Name: _____ OHIP #: _____

Patient Email _____ Patient Telephone _____

Patient DOB _____ Fax or Email Notify _____

Referral Information

Inflammatory Arthritis : ☐ **[< 6 WEEKS]** ☐ **[6 WEEKS- 6 MONTHS]** ☐ **[> 6 MONTHS]**

Osteoarthritis **: (HPI)**_____

Joint Swelling: **YES** ☐ ☐ **NO** **Which Joint:**_____

Other info:_____

☐ PSORIASIS (PERSONAL/FAMILY HISTORY) ☐ INFLAMMATORY BOWEL DISEASE

☐ ANKYLOSING SPONDYLITIS ☐ UVEITIS/IRITIS ☐ + HLA B27

☐ + RF TITRE____ and/or +CCP TITRE_____ ☐ + ANA TITRE_____ and/or +ENA Titre _____

☐ SUSPECT AUTOIMMUNE/CONNECTIVE TISSUE ☐ INTERSTITIAL LUNG DISEASE

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OTHER INFORMATION