# RHEUMATOLOGY RAPID ASSESSMENT CLINIC

## Referral Form Choose Location

**PRIVACY AND CONFIDENTIALITY**

Arthritis Society Canada has policies and procedures to protect any personal health information collected, used, and disclosed by the Rheumatology Rapid Assessment Clinic. These policies and procedures meet the requirements of the Personal Health Information and Protection Act, and guidelines from the Information and Privacy Commission of Ontario.

**GENERAL REFERRAL GUIDELINES**

- By signing this referral form, you agree to:
  - Facilitating further investigation requests as recommended by the ACPAC (i.e., labs, imaging);
  - Allowing the ACPAC to forward this referral (with your billing info) directly to the Rheumatologist, as appropriate.
- Continue to send urgent referrals directly to the appropriate Specialist (i.e., septic arthritis, vasculitis such as giant cell arteritis, connective tissue disease with major organ decompensation).

**PATIENT DEMOGRAPHICS**

| | | |
|---|---|---|
| First Name: | Last: | Middle: |
| Date of Birth (MM/DD/YY): | Age: | Gender: |
| Address: | ON City: | Postal Code: |
| Primary Phone: | Email: | |
| HCN: | | Version Code: |

**REASON FOR REFERRAL**

Rheumatic Complaint(s) & Feature(s):

Duration of Symptoms: ☐ <6mos ☐ 6-12mos ☐1-5yrs ☐>5yrs

Duration of Morning Stiffness: ☐ <30mins ☐ 30-60mins ☐>60mins

Past Medical History and Comorbidities (list or attach):

☐ Patient Profile ☐ Relevant Labs ☐ X-ray/Ultrasound/MRI Reports ☐ Other

Current Medications (list or attach):

Personal or Family History:

☐ Rheumatoid Arthritis ☐ Spondyloarthritis ☐ Uveitis

☐ Psoriasis ☐ Crohn's/Colitis ☐ Lupus

☐ Other Rheumatic Disease:

Provisional Diagnosis:

☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐Psoriatic Arthritis

☐ Crystalline Arthropathy ☐ Connective Tissue Disease

☐ Other Rheumatic Disease:

Previous rheumatology consultation? ☐ No ☐ Yes (attach reports)

Has a rheumatology referral been made? ☐ No ☐ Yes

Affected Joints/Regions:

| | LEFT | RIGHT |
|---|---|---|
| Jaw | ☐ | ☐ |
| Neck | ☐ | |
| Sternum | ☐ | |
| SC Joint | ☐ | ☐ |
| AC Joint | ☐ | ☐ |
| Shoulder | ☐ | ☐ |
| Elbow | ☐ | ☐ |
| Wrist | ☐ | ☐ |
| Hand | ☐ | ☐ |
| Fingers | ☐ | ☐ |
| Sacrum | ☐ | |
| Hip | ☐ | ☐ |
| Knee | ☐ | ☐ |
| Ankle | ☐ | ☐ |
| Toes | ☐ | ☐ |

☐ Other:

**REFERRAL SOURCE**

| | |
|---|---|
| Name: | Billing#: |
| Address: | |
| Phone: | Fax: |
| Signature: | Date (MM/DD/YY): |

**Please fax all relevant reports (i.e., cumulative patient profile, labs, imaging, specialist letters) WITH this referral form to 1.888.519.6869**