RHEUMATOLOGY RAPID ACCESS REFERRAL

ARTUS HEALTH CENTRE

839 West Broadway
Vancouver, BC
Phone: 604-875-0880
Fax: 604-875-0890

Please use this form if you believe the patient requires ***rapid assessment of the symptoms / signs of inflammatory arthritis listed below.*** (Otherwise please refer the patient in the usual way for your practice)

Artus Health Centre will see patients with suspected inflammatory arthritis with a completed referral form within 2-4 weeks of receipt of referral.

Patient Details PHN: _____

Surname:

First Name: DOB:

Address:

Mobile No: Tel day:

Tel Evening:

First language: Interpreter required: Yes ☐ No ☐

Gender: Male ☐ Female ☐ Wheelchair Assistance: Yes ☐ No ☐

Referring Physician Details

Name:

Address:

Telephone:

Fax:

MSP No. _____

Duration of Symptoms (Please tick relevant box) < 6 weeks ☐ < 6 months ☐

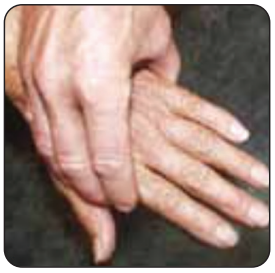
Please tick if any of the below are positive

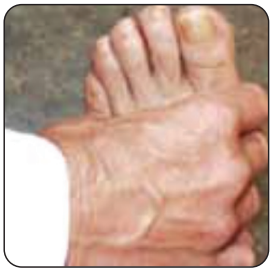
New Monoarthritis ☐

3 or more swollen joints ☐

MCP / MTP invlvement (squeeze test positive) ☐

Early Morning Stiffness > 30 minutes ☐





Personal or family Hx of: ☐ Psoriasis ☐ Colitis ☐ Uveitis ☐ Gout

Personal Hx of: ☐ Back Pain of Stiffness ☐ Recent Infective Illness

Investigations* - the following blood tests should be done in all patients with suspected inflammatory arthritis:
CBC, CRP, Rheumatoid Factor, Anti CCP (where available), ANA, U&E, LFTs, Urate

ESR	☐ Tick if completed	Results:
CRP	☐ Tick if completed	Results:
Rheumatoid Factor	☐ Tick if completed	Results:
Anti CCP	☐ Tick if completed	Results:

*Please append relevant test results

Please fill in relevant sections below (or provide this information in the form of a letter)

Referring Notes

Medical Conditions

Drug Allergies

Current Medications

MD Signature _____ Referral Date _____