NL Health Services

Rheumatology Outpatient Referral

HCN: _____

Province/Territory: _____ Expiry: _____

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F ☐ UN

Mailing Address: _____

City: _____

Province/Territory: _____ Postal Code: _____

Telephone: (Indicate Preferred) ☐ Home _____

☐ Cell _____ ☐ Work _____

Ordering Provider's Name: _____ **Clinic Stamp**:(include fax, provider and mnemonics)

Clinic Name: _____

Mailing Address: _____

City: _____

Province/Territory: _____ Postal Code: _____ Ordering Provider's Meditech Mnemonic: _____

Phone: _____ Fax: _____ EMR Clinic Mnemonic: _____

Signature: _____ Date: _____ COPY TO PROVIDER

Note: Referrals for patients who suffer from chronic non-inflammatory rheumatic disorders such as osteoarthritis, mechanical neck and low back pain, or fibromyalgia have been suspended until further notice.

Diagnosis (if known): _____

Reason for Referral: _____

Significant Medical History: ◯ None ◯ Yes (Details):

Current Medications (include dose and frequency): ◯ None ◯ Yes

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Has the patient been previously assessed by a Rheumatologist? (attach latest report)

◯ No ◯ Yes If yes, who? _____

Does the patient wish to see a specific Rheumatologist? (If yes, the wait time may be longer.)

◯ No ◯ Yes If yes, who? _____

How long has the patient had this problem?

◯ Less than 6 months ◯ 6-12 months ◯ Greater than 12 months (years _____)

Is there morning joint stiffness lasting: ◯ Greater than 1 hour ◯ Less than 1 hour

Does the patient or any family member have psoriasis? ◯ No ◯ Yes

Details: _____

Suspected Condition: (Please order identified investigations)

☐ **Inflammatory Arthritis**
CBC, CRP or ESR, creatinine, ALT/ALP, Rheumatoid Factor (RF), X-Rays (Involved joints)

☐ **Connective Tissue Disease**
CBC, CRP or ESR, creatinine, ALT/ALP, RF, ANA, ENA profile, CK, Urinalysis

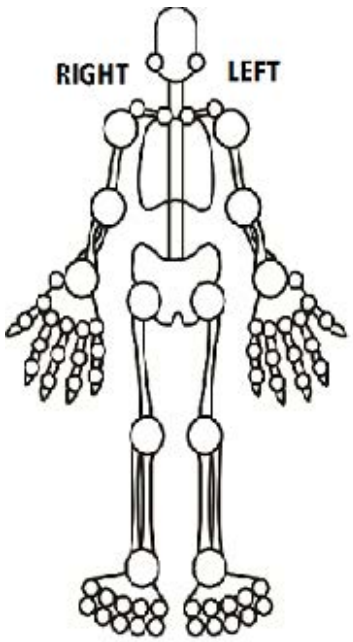
☐ **Inflammatory Back Pain**
CBC, CRP or ESR, creatinine, ALT/ALP, HLA-B27, X-Rays (A-P pelvis)

☐ **Polymyalgia Rheumatica**
CBC, CRP or ESR, ALT/ALP, RF, CK

☐ **Vasculitis/Giant Cell Arteritis**
CBC, ESR, CRP, creatinine, ALT/ ALP, RF, ANA, ANCA, Urinalysis

☐ **Other**

Please shade only SWOLLEN joints:



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Date of Birth: _____ Sex: ☐ M ☐ F ☐ UN

Rheumatology Outpatient Referral

Please provide ONLY investigations required for the condition you suspect:

Mandatory Investigations	Result	Date	Condition-Specific Investigations	Result	Date
CBC			RF		
☐ CRP ☐ ESR			ANA		
Creatinine			ENA Profile		
ALT/ALP			CK		
			HLA-B27		
			Urinalysis		
			ANCA		
			Uric Acid		

Please note all sections of the referral must be completed for processing.
Incomplete or illegible forms will be returned.
Forward to: Rheumatology Department
St. Clare's Mercy Hospital, St. John's, NL, A1C 5B8, Tel: 709-777-5265, Fax: 709-777-5936

Rheumatology Urgency Classifications and Descriptions*

Urgency	Description	Examples
Priority 1A	Acute non-traumatic inflammatory rheumatic disorders requiring prompt intervention	Active inflammatory arthritis such as Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, uncontrolled polyarticular Gout
	Severe Connective Tissue Disease	Myositis Acute stage of Systemic Lupus Erythematoosus (SLE) Scleroderma
	Systemic Vasculitis	Granulomatosis with Polyangiits (GPA)
	Temporal Arteritis	
Priority 1B	Sub-acute non-traumatic inflammatory rheumatic disorders	Relatively stable inflammatory conditions such as: Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, SLE
		Polymyalgia Rheumatica (PMR)
Priority 2	Chronic rheumatic inflammatory conditions	Erosive nodal Osteoarthritis; Gout; Pseudogout/ Calcium Pyrophosphate Deposition Disease (CPPD)

*Developed by the Rheumatology Waitlist Management Committee, Eastern Health, February 2007, Revised April 2019.

Patients with polyarticular inflammatory disease will be contacted to schedule an assessment by a member of the interdisciplinary team (i.e., Physiotherapist, Occupational Therapist, or Nurse Practitioner) to determine appropriate triage urgency and initiate early intervention as appropriate.

Patients have the option of being scheduled for an appointment with the next available Rheumatologist or the Rheumatologist of their choice. Please note there may be a longer waiting time for the Rheumatologist of choice.

You will receive confirmation of receipt of your referral within ten business days. Your patient will be contacted to confirm an appointment time when one becomes available.

Office Use Only: Date of Receipt: _____ Date of Triage: _____

Urgency: ◯ Priority 1A ◯ Priority 1B ◯ Priority 2 ◯ Return Signature: _____

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