☐ Osteoporosis Clinic
☐ Osteoarthritis Clinic
☐ Early Inflammatory Arthritis Clinic
☐ General Rheumatology Clinic
FAX to: (905)235-0332

The Centre of Arthritis Excellence (CArE) Referral Form

Patient Name:	Physician Name:
Date of Birth:	Billing Number:
Address:	Address:
Health Card Number:	Phone: Fax:

Reason for referral:

Provisional diagnosis:
☐ Inflammatory Arthritis ☐ Crystaline (gout) ☐ Connective Tissue Disease ☐ Fibromyalgia
Is participation in daily activities impacted by illness? ☐ Y ☐ N

Age: Gender:

Duration of symptoms:

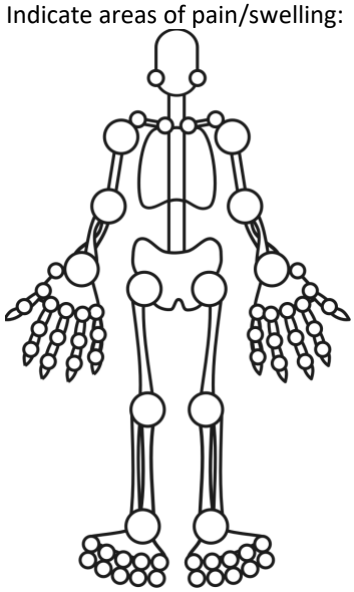
☐ < 6m ☐ 6-12m ☐ >12m ☐ years (#_____)

Past Medical History:

Current Medications (transcribe or attach list):

Family history:
- Anklosying Spondylitis
- Lupus
- Psoriasis
- Inflammatory Bowel Disease
- Rheumatoid Arthritis

Indicate areas of pain/swelling:



Duration of morning stiffness:

☐ < 30min ☐ >30min ☐ >60m

Before sending referral, please be sure you have included:
- Relevant investigations and reports
- Completed homunculus (above)
- Past medical history
- Current medications
- Indication of clinic for referral triage purposes (see header)
- Most recent Bone Mineral Density results for Osteoporosis referrals

Please note that incomplete referrals will not be triaged until all necessary information is received. Be sure to include all relevant information to avoid unnecessary delays.