CArE Centre of Arthritis Excellence
A Regional Program... A National Resource

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Email: info@carearthritisteam.ca

The Centre of Arthritis Excellence (CArE) – Referral Form

Patient Name - First:	Last:	Middle:
Date of Birth (MM-DD-YYYY):	Age:	Gender:
Address:	City/Prov.:	Postal Code:
Phone Number:	Email:	
Health Card Number:	Version Code:	

Reason for Referral:

Provisional Diagnosis: (select one) Other - please specify:

Is participation in daily activities impacted by illness? ○ Yes ○ No

Duration of symptoms: ○ < 6 mos ○ 6 - 12 mos ○ Years - please specify:

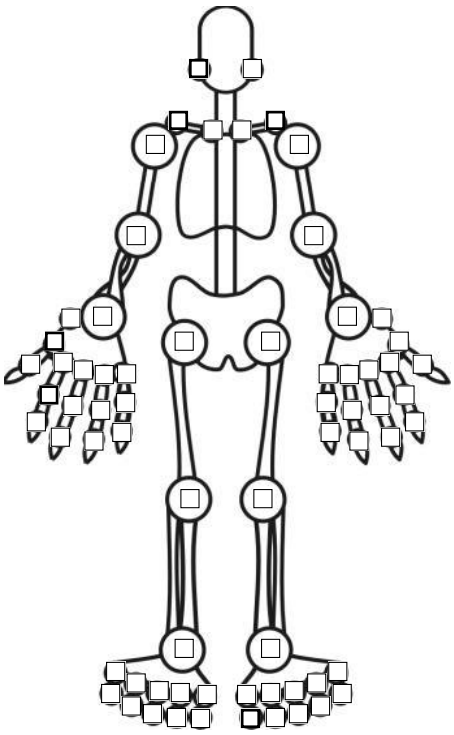
Duration of morning stiffness: ○ < 30 min ○ 30 - 60 min ○ > 60 min

Past Medical History (Please attach additional pages as needed, incl. bloodwork and imaging):

Current Medications (Please attach list/additional pages as needed):

Family History of Inflammatory/Auto-Immune Condition (i.e. Psoriasis, IBD, RA): ○ Yes ○ No

Indicate the areas of pain/swelling:



- PLEASE NOTE THAT INCOMPLETE REFERRALS WILL NOT BE TRIAGED UNTIL ALL REQUIRED INFORMATION IS RECEIVED -

To avoid unnecessary delays, please ensure ALL of the above questions are answered and any additional relevant investigations and reports are attached

OSTEOPOROSIS referrals must also include most recent Bone Mineral Density results

Physician Name:	Billing Number:
Phone Number:	Fax Number:
Signature:	Date (MM-DD-YYYY):

PLEASE FAX COMPLETED REFERRAL FORM AND ACCOMPANYING DOCUMENTS TO:

(905) 235-0332