CArE Referral Form

108-465 Davis Drive, The Tannery Mall
Newmarket, ON L3Y 7T9
PH: 905-235-9990 FAX: 905-235-0332

Patient Name: _____ Address: _____ _____ Contact Phone No.: _____ Date of Birth: _____ Health Card No.:	Referring Physician Name: _____ Address: _____ _____ Phone No.: _____ Fax No.: _____ OHIP Billing No.: _____ Signature

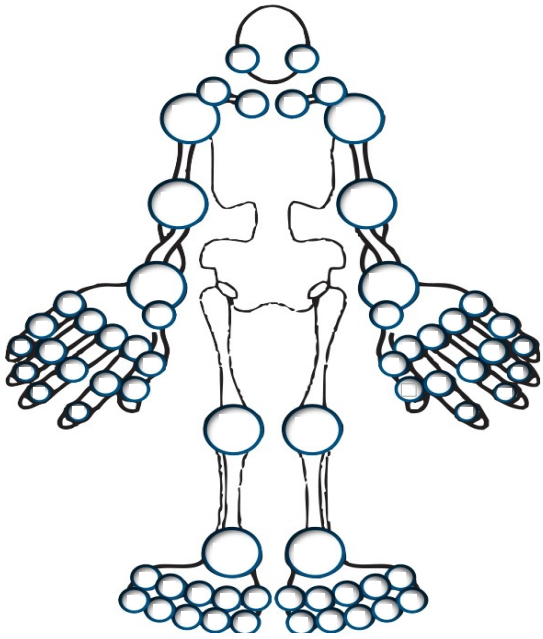
CArE DOES NOT ACCEPT REFERRALS FOR SECOND OPINION OR TRANSFER OF CARE.

Reason for Referral/ Suspected Diagnosis (If Osteoporosis (OP) - please complete OP Referral Form HERE):

☐ Joint Injection, if considered
Site: _____

Relevant medical history:
Append cumulative patient profile, if available.

Indicate area of pain/swelling



MSK Assessments

PLEASE NOTE THAT ALL PATIENTS WILL RECEIVE AN MSK ASSESSMENT BY ONE OF OUR INTERDISCIPLINARY HEALTH PROFESSIONALS AND WILL SEE A RHEUMATOLOGIST ONLY IF DEEMED APPROPRIATE.

History of Disease

How long has the problem been present?
☐ 6 weeks ☐ 6 weeks to 6 months ☐ > 6 months

Does the patient have morning stiffness?
☐ 30 minutes ☐ 30-60 minutes ☐ > 60 minutes

Is the patient limited in activities or had to stop work or school due to THIS PROBLEM?
☐ Yes ☐ No

Additional Features: _____

☐ URGENT (Within 1 week) ☐ SEMI-URGENT (1-4 weeks) ☐ ROUTINE (2-8 weeks)

Refer to Workshops/ Hand Splinting

☐ Inflammatory Arthritis (IA) Therapeutic Education Workshop
☐ Osteoarthritis (OA) Therapeutic Education Workshop
☐ Osteoporosis (OP) Therapeutic Education Workshop (Please complete OP Referral Form HERE)
☐ Fibromyalgia (FM) Therapeutic Education Workshop
☐ Hand Splinting

NOTE: Please attach copies of imaging reports, any relevant consultations, treatments and surgical notes.

PLEASE FAX COMPLETED REFERRAL FORM AND ACCOMPANYING DOCUMENTS TO: 905-235-0332

Version: July 2026