

# Early Inflammatory Arthritis Clinic Referral Form



## West Mountain Medical Centre

120 San Antonio Drive, Unit 3, Hamilton L9C 5N2  
Tel: 905.574.9999 Fax: 905.5748799

Dr. Manisha Mulgund MD FRCP (Rheumatologist)

Please use this form if you believe the patient requires rapid assessment of the symptoms/ signs of inflammatory arthritis listed below. Urgent appointments within 2 weeks. (Otherwise please refer the patient in the usual way for your practice)

- STEP 1: Complete patient details below (tick all boxes)

Patient Name: patName Address: patAddressLabel DOB: patBirthdate.default Phone: patHomePhone.default	Physician Name, Phone, Fax, Address (may insert sticker/stamp here) patMdName currMdPhone.default currMdFax.default currMdAddressLabel OHIP Billing #: patMdPhysNum Physician Signature: <div style="border: 1px solid black; width: 150px; height: 30px; display: inline-block;"></div>
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Duration of Symptoms	<input type="checkbox"/> <4 Weeks	<input type="checkbox"/> <6 Months	<input type="checkbox"/> <1yr
<input type="checkbox"/> 2 or More Swollen Joints	ESR:		
<input type="checkbox"/> MTP/MCP Involvement (squeeze test positive)	CRP:		
<input type="checkbox"/> Morning Stiffness > 30 Minutes	Date:		
<input type="checkbox"/> Back Pain with Stiffness > 30 Minutes	<input type="checkbox"/> Recent Infective Illness		
Personal or Family History of:	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Colitis	<input type="checkbox"/> Uveitis
Referral Date: currentDate.default			

- STEP 2: Please attach recent medical history, medications, known allergies
- STEP 3: Please send a copy of pre-visit CBC, ESR, Renal Liver and Bone profile, CRP, Urate, Rheumatoid Factor, Anti-CCP antibody test, ANA and X-ray of affected joint (or provide with results if already done or CC us a copy if results pending)
- STEP 4: Tick if blood have been done and Fax to 905-574-8799 ☐

**Fax to 905-574-8799**

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