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Family Medicine & Primary Care Rheumatology
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Patient Information:

Name:_____

D.O.B.:_____

Address:_____
City:_____ Province:_____

Postal Code:_____
Tel#:_____

Health Card:_____

Referring Physician:_____

Billing#:_____CPSO#:_____

Address:_____

City:_____ Province:_____
Postal Code:_____

Tel:_____ Fax:_____

Signature:_____

Please indicate which clinic you are referring to:

- ☐ Rapid access joint injection clinic*
- ☐ New/ suspected arthritis clinic
- ☐ Fibromyalgia assessment clinic
- ☐ Rheumatologic triage clinic

*If you are referring to the rapid access joint injection clinic, indicate which joint(s):

RightShoulder		Right GTBursa	
Left Shoulder		Left GT Bursa	
Right Elbow		Right Knee	
Left Elbow		Left Knee	
Right Wrist		Right Ankle	
Left Wrist		Left Ankle	
IP/MCP/CMC		MTP(s)	

Indicate the most likely/ suspected diagnosis: _____
Relevant History: (/attach separately)

Are you practicing within a FHO/FHN model? Y | N
List any previously ordered labs:(attach reports separately)_____
List any previously ordered imaging: (attach reports separately)_____

The referring physician's office and the patient will be contacted directly with the date and time of the appointment after triage of this referral.