William Osler Health System

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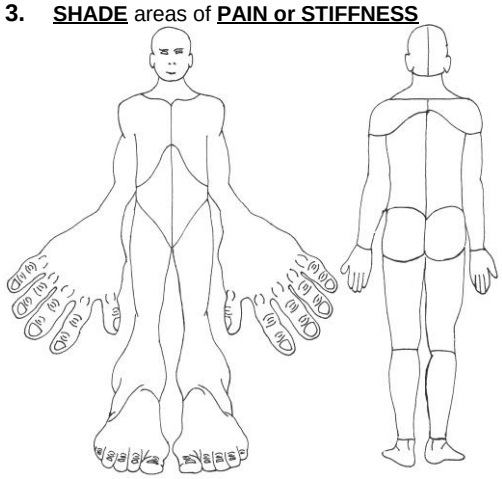
MSK HEALTH: CANADIAN ARTHRITIS REFERRAL TOOL (CART)

PATIENT NAME:	**PHYSICIAN NAME:**

DATE OF BIRTH:	**PHONE:**
ADDRESS:	**FAX:**
	ADDRESS:
PHONE:	
HCN:	**PHYSICIAN #:**

HISTORY (★PATIENT OR PHYSICIAN TO COMPLETE★)

1. **AGE:** **2.** **GENDER:** ☐Male ☐Female → **3.** **SHADE** areas of **PAIN or STIFFNESS**



4. **HOW LONG** have you had **THIS PROBLEM**? ☐< 6 m ☐< 12 m ☐ > 1 yr ☐ > 5 yr

5. What does your joint pain or stiffness **GET BETTER** with?
☐Activity *(Keep moving)* ☐Rest *(Sit or Lie down)* ☐Other:

6. Have you noticed **OBVIOUS SWELLING** in your **JOINTS**? ☐ YES ☐ NO
*If YES, **WHICH JOINTS** are **SWOLLEN**?*
☐Fingers ☐Wrists ☐Elbows ☐Knees ☐Ankles ☐Feet

7. Have you **STOPPED WORKING** because of **THIS PROBLEM**? ☐YES ☐NO ☐N/A

8. Do you or any of your family members have **PSORIASIS**? ☐YES ☐NO

9. Check if **YOU HAVE** any of the following conditions: ☐Rheumatoid Arthritis
☐Psoriatic Arthritis ☐Lupus ☐Ankylosing Spondylitis ☐Gout ☐Fibromyalgia
If so, do you think you may be "flaring"? ☐YES ☐NO

10. **HOW LONG** does your **MORNING STIFFNESS last** from the time you wake up? *(place mark on line)*

0 ½ hr 1 hr 1½ hrs 2 hrs +

PHYSICAL EXAMINATION (★ PHYSICIAN TO COMPLETE ★)

11. **WHICH JOINTS** are **SWOLLEN** on **EXAMINATION**? ☐None ☐Not Sure ☐Fingers ☐Wrists ☐Elbows ☐Knees ☐Ankles ☐Feet

12. Other **RELEVANT** Physical Exam Findings:

LABORATORY & IMAGING (★ ★ PLEASE ATTACH ALL LAB & IMAGING REPORTS ★ ★)

Hgb: WBC: PLT: ESR: CRP: RF: CCP: ANA:

DIAGNOSIS (★ PHYSICIAN TO COMPLETE ★)

13. What do **YOU THINK** is the **DIAGNOSIS:** _____

14. **CLASSIFY** the **PROBLEM:**

☐Inflammatory Condition
- ☐ Rheumatoid Arthritis : Please fax to Early Arthritis Centre
- ☐Psoriatic/Reactive Arthritis ☐ Ankylosing Spondylitis ☐ PMR
- ☐Lupus/Connective Tissue Disease ☐Vasculitis ☐Crystalline (Gout or CPPD)

☐Mechanical/Degenerative Condition (☐Osteoarthritis, ☐Mechanical Back Pain etc)

☐Chronic Pain Condition (☐Fibromyalgia) ☐Other:

15. Has this Patient **EVER** seen a Rheumatologist Before? ☐NO ☐Not Sure ☐YES (*please attach all consult notes*)

16. Is this Problem related to a **PRIOR INJURY**? ☐YES ☐NO

17. How **SOON** does this patient **NEED** to be **ASSESSED**? ☐24-48 hrs *(call)* ☐2-8 Weeks ☐2-4 Months ☐4-6 Months

18. Please **ATTACH** any **OTHER INFORMATION** you think is important (i.e. PMH, current meds, other investigations. immunizations)

Signature: _____ Date:_____