

STREAMLINED TOOL FOR ARTHRITIS REFERRALS

Brampton Rheumatology Associates:

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Patient Name:

Address:

Contact Phone #:

Date of Birth:

Health Card #:

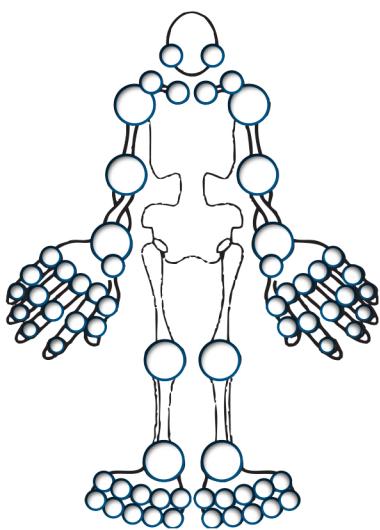
Physician Name:

Address:

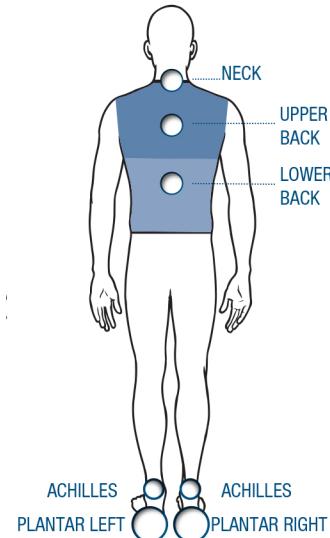
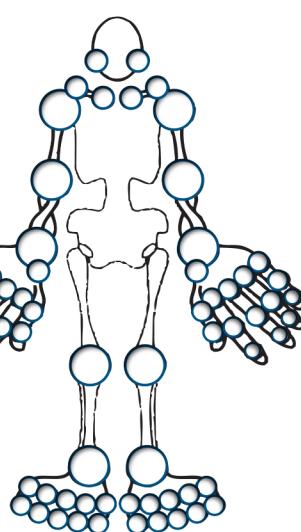
Phone #:

Fax #:

Tender Joints:



Swollen Joints:



All fields must be filled out for an appointment to be issued

History – Physician to Complete

Reason for Referral:

Comments/Treatments Tried:

How long has the problem been present? < 3 months 3-6 months > 6 month

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

Functional Impairment Has the patient had to stop work or school due to THIS PROBLEM yes no

Psoriasis (ever) Inflammatory bowel disease (IBD) Uveitis Other: _____

Please send the following Investigations if done (all investigations must accompany referral)

CBC ESR CRP ORF ANA Creatinine Urinalysis Attach x-ray reports of the affected joints

Diagnosis

What do you think is the diagnosis?

Inflammatory (RA/PSA/AS/CTD/Vasculitis) Chronic Pain (FM/CFS)

Non-inflammatory (OA/Mechanical/LBP) Emergency (vasculitis, temporal arteritis)

page rheumatologist on call at 416-747-3500

Comments/Other: _____

Has the patient seen a rheumatologist before

no not sure yes (attach copy of all consult notes)

Please attach any other information that you think is important

Please inform your patient that they may be pre-assessed by our extended role provider (PT, OT, RN)

URGENT

If urgent, page rheumatologist on call at 416-747-3500

SEMI-URGENT

ROUTINE