

♦ **CANADIAN ARTHRITIS REFERRAL TOOL (CART)**

DATE: _____

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PATIENT NAME:	PHYSICIAN NAME:
DATE OF BIRTH:	PHONE:
ADDRESS:	FAX:
PHONE:	ADDRESS:
HCN:	PHYSICIAN #:

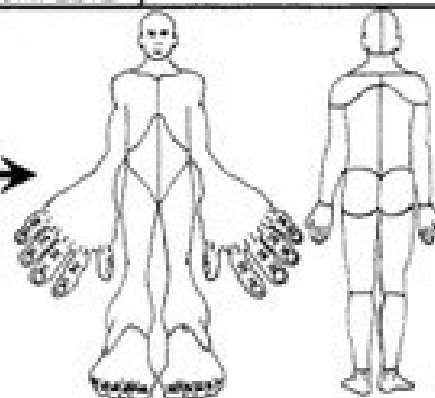
HISTORY (*PATIENT OR PHYSICIAN TO COMPLETE*)

1. AGE: _____ 2. GENDER: ☐ Male ☐ Female

3. **HOW LONG** have you had this problem?

☐ < 3 months ☐ < 6 months ☐ 6 – 12 months ☐ > 12 months

4. **ON THE DIAGRAM**, please shade areas of **PAIN or STIFFNESS**?



5. How **LONG** does any **MORNING STIFFNESS** or **SORENESS LAST**?

☐ >60 minutes ☐ 30-60 minutes ☐ < 30 minutes ☐ None

6. Have you noticed **OBVIOUS SWELLING** in your Joints?

☐ YES ☐ NO ☐ Not Sure

IF YES, WHICH JOINTS are **SWOLLEN**?

☐ Fingers ☐ Wrists ☐ Elbows ☐ Knees ☐ Ankles ☐ Feet

7. Does your joint pain or stiffness **GET BETTER** with ... ☐ Activity ☐ Rest ☐ Other _____

8. Do you have **NEW SKIN PROBLEMS OR RASHES**? ☐ YES ☐ NO

PSORIASIS? ☐ YES ☐ NO

9. Do you have a **DEFINITE FAMILY HISTORY** of Rheumatoid Arthritis? ☐ YES ☐ NO

PHYSICAL EXAMINATION (* PHYSICIAN TO COMPLETE *)

10. Are the Joints **SWOLLEN** on **EXAMINATION**? ☐ YES ☐ NO ☐ Not Sure

IF YES, WHICH JOINTS are **SWOLLEN**?

☐ Fingers ☐ Wrists ☐ Elbows ☐ Knees ☐ Ankles ☐ Feet

11. Other **RELEVANT** Physical Exam Findings: _____

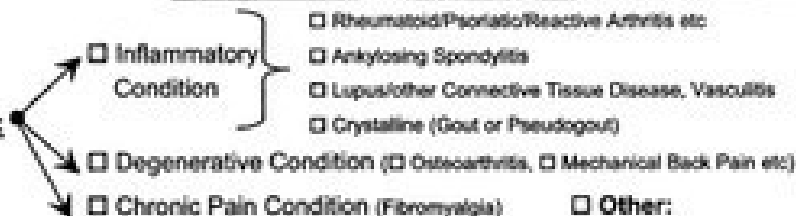
LABORATORY & IMAGING (* * PLEASE ATTACH ALL LAB & IMAGING REPORTS IF DONE * *)

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

DIAGNOSIS (* PHYSICIAN TO COMPLETE *)

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

13. **CLASSIFY** the **PROBLEM**:



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

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

16. Rate the **URGENCY** of this Referral? ☐ Emergency (please call) ☐ Urgent ☐ Semi-Urgent ☐ Elective

17. Please **LIST OR ATTACH** any **OTHER INFORMATION** you think is important

Signature: _____