Referral Form: North West Rheumatic Disease Central Intake

Fax: 1-807-343-0144

Surname:	Mobile #	Address:
First:	Home #	
DOB:	Business #	
HN:	Email:	□ Alternate contact:
Gender: □ Male □Female □Other	Best method of contact: □Mobile □Home □Business □Email □Alternate	
Preferred language: □English □French □Other		
Preferred pronoun: □ She/Her □He/Him □They/Them □Other	Accessibility concerns or disability: □ Falls risk □Patient requires lift □Wheelchair □Hearing Impaired	□ Unsafe to contact persons (do not speak with):
Preferred name:		

Special Considerations: (e.g. barriers, tips for care delivery, 3rd party insurance, patient requires escort, cognitive issues)

□ Send copies of reports to additional providers (i.e. primary care provider)
Name(s):
Contact information:

Triage Requested Priority: □ Routine □ Urgent with reason for urgent referral:
□ Second opinion

Concern(s)/ Indication(s) Triggering Referral

Select all that apply:

□ Crystal Arthropathies (Gout, Pseudogout)
□ Connective Tissue Diseases (Lupus, Sjogren's, Scleroderma, Inflammatory Myositis)
□ Inflammatory Arthritis (e.g. Rheumatoid arthritis)
□ Polymyalgia Rheumatica
□ Psoriatic Arthritis
□ Spondyloarthritis
□ Vasculitis
□ Other:

Clinical Question/ Goal(s) or Referral with Relevant History, Management & Investigations (*Please attach all relevant laboratory and diagnostic investigations*):

Cumulative Patient Profile (CPP): □ CPP attached separately (if not entered below)

Current Problem List:

Past Medical History:

Current Medications:

Family History:

Allergies:

Preferred Consultant or Location All patients will be triaged to the shortest wait time unless a preferred consultant or location is entered.
□ Preferred consultant or location:

Other considerations:

Name:	Site name:
Billing #:	Address:
Phone:	
Fax:	
Signature:	