



Rheumatology Referral & Triage Form:

Please complete all fields & fax to 514-934-4404

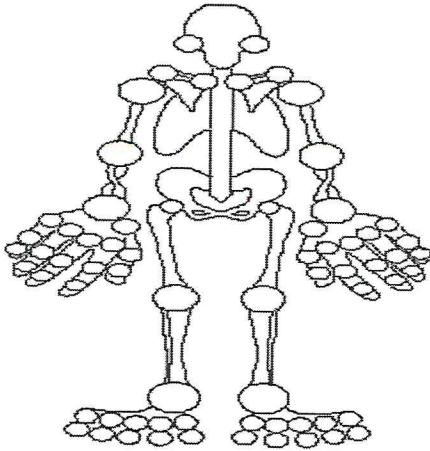
Referrals go to general rheumatology; unless requesting a particular physician (if so, name): _____

Date (dd/mm/yy):	Patient Name: _____ DOB: _____
Referring MD Name:	RAMQ#: _____ MGH or RVH#: _____
License #:	Home #: _____ Cell or Work #: _____
Telephone: _____ Fax: _____	Address: _____
Address:	
Signature:	

Do you consider this referral to be urgent? (see table in folder) No Yes
If yes, page MUHC rheumatologist on call 514-934-1934 x 43333

IF PATIENT HAS >3 SWOLLEN JOINTS OR INVOLVEMENT OF MCP/MTP JOINTS OR AM JOINT STIFFNESS >30 MIN, SUSPECT RHEUMATOID ARTHRITIS & REFER URGENTLY.
Severe night-time pain and/or systemic symptoms such as fever or weight loss suggest serious pathology and should hasten referral for any rheumatic complaint.

ARE THERE PAINFUL JOINTS? No Yes:
Mark an X or line through any painful joints



List current treatment for rheumatic complaint: (NSAIDs, prednisone, physio etc.) & any prior treatment of relevance (& side effects, if any).

Is there morning joint stiffness lasting for
> 30 minutes? Yes No
> 60 minutes? Yes No

Does the pain disturb sleep? Yes No
Has there been weight loss? Yes No
Has the patient been Dx with psoriasis Yes No

Summary of present illness (include SYMPTOM DURATION & any limitations of daily activities):
For how long has the patient had this problem? <6mo 6-12mo >12mo Years (Number _____)
Is the patient limited in activities of daily living (dress, eat, bath) Yes No

PROVISIONAL DIAGNOSIS: _____
 Inflammatory arthritis Crystalline (CPPD/Gout) OA Connective tissue disease Fibromyalgia

Please fax any relevant reports (labs, imaging, specialist letters) with this referral sheet.



In order to improve the triage of consults ensuring timely evaluation of patients in need of rheumatology evaluation we kindly request that you please:

1. Use the following triage grading system that will allow you to direct your consult,
2. Complete the referral form and fax it to the Division of Rheumatology.

**Division of Rheumatology
McGill University Health Centre**

CATEGORY	DESCRIPTION	EXAMPLES	PROCESS
A+	For patients who require assessment and treatment on an urgent basis within 24-48 HOURS .	<ul style="list-style-type: none"> - Septic arthritis - Giant cell arteritis - CTD with major organ decompensation 	Physicians should personally contact the ON CALL RHEUMATOLOGIST (514-934-1934 ext 53333) or refer the PATIENT TO THE ER .
A	For patients who require assessment and treatment on an emergent basis within 2-4 WEEKS .	<ul style="list-style-type: none"> - New onset IA - CTD - Vasculitis - PMR 	Fax referral to: 514-934-4404
B	For patients who require assessment and treatment on an elective basis within 2-4 MONTHS .	<ul style="list-style-type: none"> - Established IA - Crystalline arthritis - Severe OA/regional pain syndromes with a major impact on ADLs 	Fax referral to: 514-934-4404
C	For patients who require assessment and treatment on an elective basis within the next 6-12 MONTHS .	<ul style="list-style-type: none"> - Previously diagnosed rheumatic disease (stable) referred for diagnostic reevaluation or review of treatment - FM not previously seen by rheumatologist - Possible IA but not deemed highly likely - OA which may benefit from consultation 	Fax referral to: 514-934-4404
D	Appointments are not given unless discussed with referring physician. Reserved for patients with established chronic pain conditions who would be better treated by specialists in orthopedics, chronic pain, or rehabilitation.	<ul style="list-style-type: none"> - Diagnosed FM - Chronic MBP - Chronic soft tissue pain 	A consult with rheumatology may take up to 1 year.

IA = Inflammatory Arthritis, CTD = Connective Tissue Disease, OA = Osteoarthritis, ADLs = Activities of Daily Living, FM = Fibromyalgia, MBP = Mechanical Back Pain.