The Arva Clinic Referral Form

☐ I agree to allow this consult to go to the next available Rheumatologist (f: 519-672-5007)
☐ Dr. Andy Thompson,f: 519-672-5007 ☐ Dr. Madison Leitch, f: 519-679-4901
☐ Dr. Maeve Gamble, f: 519-679-3531 ☐ Dr. Carly Hewson, f: 519-672-9439
☐ Dr. Michael Arnold, f: 519-672-7474

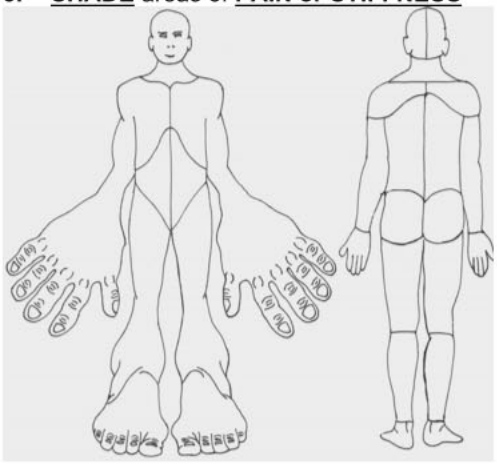
the arva clinic

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

HISTORY (★PATIENT OR PHYSICIAN TO COMPLETE★)

1. **AGE:** 2. **GENDER:** →

3. **SHADE** areas of **PAIN or STIFFNESS**



4. **HOW LONG** have you had **THIS PROBLEM**? ☐ < 6 m ☐ < 12 m ☐ > 1 yr ☐ > 5 yr
5. Are you **ABORIGINAL**? ☐ YES ☐ NO
6. What does your joint pain or stiffness **GET BETTER** with?
   ☐ Activity *(Keep moving)* ☐ Rest *(Sit or Lie down)* ☐ Other:
7. Have you noticed **OBVIOUS SWELLING** in your **JOINTS**? ☐ YES ☐ NO
   *If YES, **WHICH JOINTS** are **SWOLLEN?***
   ☐ Fingers ☐ Wrists ☐ Elbows ☐ Knees ☐ Ankles ☐ Feet
8. Have you **STOPPED WORKING** because of **THIS PROBLEM**? ☐ YES ☐ NO ☐ IN/A
9. Do you or any of your family members have **PSORIASIS**? ☐ YES ☐ NO
10. 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
11. **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 ★)

12. **WHICH JOINTS** are **SWOLLEN** on **EXAMINATION**? ☐ None ☐ Not Sure ☐ Fingers ☐ Wrists ☐ Elbows ☐ Knees ☐ Ankles ☐ Feet
13. Other **RELEVANT** Physical Exam Findings:

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

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

DIAGNOSIS (★ PHYSICIAN TO COMPLETE ★)

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

15. **CLASSIFY** the **PROBLEM:**
    ☐ Inflammatory Condition { ☐ Rheumatoid/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:
16. Has this Patient **EVER** seen a Rheumatologist Before? ☐ NO ☐ Not Sure ☐ YES (*please attach all consult notes*)
17. Is this Problem related to a **PRIOR INJURY**? ☐ YES ☐ NO
18. How **SOON** does this patient **NEED** to be **ASSESSED**? ☐ 24-48 hrs *(call)* ☐ 2-8 Weeks ☐ 2-4 Months ☐ 4-6 Months
19. Please **ATTACH** any **OTHER INFORMATION** you think is important (i.e. PMH, current meds, labs, investigations)

Signature: _____ Date: _____