RHEUMATOLOGY RAPID ACCESS CLINIC (Rheum RAC)
Referral Form Windsor

PRIVACY AND CONFIDENTIALITY

Arthritis Society Canada has policies and procedures to protect any personal health information collected, used, and disclosed by the Rheumatology Rapid Access Clinic. These policies and procedures meet the requirements of the Personal Health Information and Protection Act, and guidelines from the Information and Privacy Commission of Ontario.

GENERAL REFERRAL GUIDELINES

- By signing this referral form, you agree to:
  - Facilitate further investigation requests as recommended by the Advanced Clinician Practitioner in Arthritis Care (ACPAC);
  - Allow the ACPAC to forward this referral (with your billing info) directly to the Rheumatologist, as appropriate.
- Continue directing urgent referrals to the appropriate specialist, such as for septic arthritis, vasculitis (e.g., giant cell arteritis), or connective tissue diseases with significant organ decompensation.

PATIENT DEMOGRAPHICS

First Name:	Last:	Middle:
Date of Birth (MM/DD/YY):	Age:	Gender:
Address:	ON City:	Postal Code:
Primary Phone:	Email:	
HCN:		Version Code:

REASON FOR REFERRAL

Rheumatic Complaint(s) & Feature(s):

Duration of Symptoms: ☐ <6mos ☐ 6-12mos ☐1-5yrs ☐>5yrs

Duration of Morning Stiffness: ☐ <30mins ☐ 30-60mins ☐>60mins

Past Medical History and Comorbidities (list or attach):

☐ Patient Profile ☐ Relevant Labs ☐ X-ray/Ultrasound/MRI Reports ☐ Other

Current Medications (list or attach):

Personal or Family History:

☐ Rheumatoid Arthritis ☐ Spondyloarthritis ☐ Uveitis

☐ Psoriasis ☐ Crohn's/Colitis ☐ Lupus

☐ Other Rheumatic Disease:

Provisional Diagnosis:

☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Psoriatic Arthritis

☐ Crystalline Arthritis ☐ Connective Tissue Disease

☐ Other rheumatic Disease:

Previous rheumatology consultation? ☐ No ☐ Yes (attach reports)

Has a rheumatology referral been made? ☐ No ☐ Yes, to: Dr.

Affected Joints/Regions:

	LEFT	RIGHT
Jaw	☐	☐
Neck	☐	
Sternum	☐	
Shoulder	☐	☐
Elbow	☐	☐
Wrist	☐	☐
Hand	☐	☐
Back	☐	
Sacrum	☐	
Hip	☐	☐
Knee	☐	☐
Ankle	☐	☐
Foot	☐	☐

☐ Other:

REFERRAL SOURCE

Name:	Billing#:
Address:	
Phone:	Fax:
Signature:	Date (MM/DD/YY):

Please fax all relevant reports (i.e., cumulative patient profile, labs, imaging, specialist reports) WITH this referral form to 1.888.519.6869