WCH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
M5S 1B2
Tel: 416-323-6344 Fax: 416-323-6115

RHEUMATOLOGY REFERRAL FORM

URGENCY: ❑ Routine ❑ Urgent ❑ Semi-Urgent

REFERRAL DATE: ___/___/_____
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ DOB: ___/___/_____
DD/MM/YYYY

Sex: ____ Email address: _____

Health card: _____ Version code: _____

Full address: _____

Telephone: _____ Alternate #: _____

SPECIFIC PHYSICIAN: ❑ No (First Available) ❑ Yes (Dr. _____)

ADDITIONAL PATIENT INFORMATION

Preferred name (*if different from above*): WCH Medical Record Number (*if known*):

Gender(*if different from above*): Pronouns: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Other

Other insurance coverage (IFH, UHIP, etc.): ❑ Self-pay

Language spoken: Interpreter required: ❑ Yes ❑ No

Allergies:

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: _____

Signature: _____

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: _____
Primary Care Provider Telephone: _____

REASON FOR REFERRAL

Reason for referral: _____

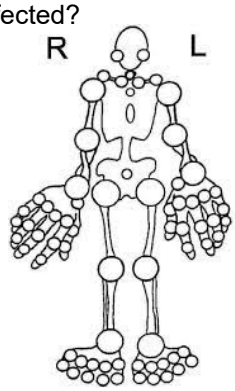
Onset of Symptoms:
☐ Less than 6 weeks
☐ 6 weeks to 6 months
☐ Greater than 6 months
Please specify: _____

Is there evidence of joint swelling?
☐ No ☐ Yes ☐ Suspected

Has the patient previously seen a rheumatologist for this concern?
☐ No ☐ Yes - If yes, please specify: _____

Are there other features suggestive of a rheumatologic condition?
☐ No ☐ Yes - If yes, please specify: _____

Please indicate which joints/body regions are affected?



FAMILY AND MEDICAL HISTORY

Current Conditions:

Past Medical Hsitory:

Medications:

Famliy History:

Please attach the following (if applicable)
☐ X-ray results
☐ Bloodwork
☐ Previous relevant consultations