



WOMEN'S COLLEGE HOSPITAL 76 Grenville Street
 Healthcare | REVOLUTIONIZED Toronto, Ontario
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RHEUMATOLOGY REFERRAL FORM

URGENCY: Routine Urgent Semi-Urgent

REFERRAL DATE: / /
 DD / MM / YYYY

PATIENT INFORMATION

(Affix Patient Label/Identification Here)

MRN: _____ HCN: _____
 Name: _____
 Sex: _____ Date of Birth: / /
 DD / MM / YYYY
 Address: _____
 Telephone: _____

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: _____

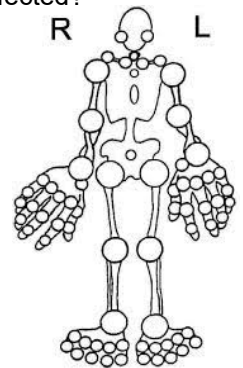
REFERRING PROVIDER INFORMATION

Name: _____ Billing #: _____
 Address: _____
 Telephone: _____ Signature: _____
 Fax: _____
 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:	Please attach the following (if applicable) <input type="checkbox"/> X-ray results <input type="checkbox"/> Bloodwork <input type="checkbox"/> Previous relevant consultations
Past Medical History:	
Medications:	
Family History:	

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