Early Inflammatory Arthritis Referral Form

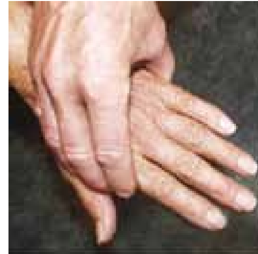
- *Please use this form if you believe the patient requires* **rapid assessment of the symptoms / signs of inflammatory arthritis listed below.** (Otherwise please refer the patient in the usual way)

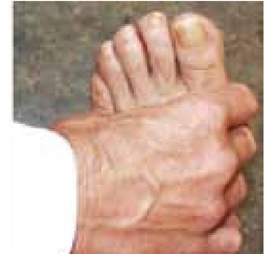
General Practitioner Details

Patient Details

Please tick if any of the below are positive

- ☐ 3 or more swollen joints
- ☐ MCP /MTP involvement (squeeze test positive)
- ☐ Early Morning Stiffness > 30 minutes





Duration of symptoms: ☐ < 6 weeks ☐ ≤ 3 months ☐ > 3 months

Personal or family Hx of: ☐ Psoriasis ☐ Inflammatory Bowel Disease ☐ Uveitis

Personal Hx of: ☐ Back Pain or Stiffness ☐ Recent Infective Illness

Investigations* the following blood tests should be done in all patients with suspected inflammatory arthritis:
(Please append relevant test results)

Test	Results		Other tests
ESR	Results:		Full blood count
CRP	Results:		Liver function tests
Rheumatoid Factor	Results:		Urea, Electrolytes & Creatinine
Anti CCP	Results:		Urate
Anti-Nuclear Antibody	Results:		

Please fill in relevant sections below (or provide this information in the form of a letter)

Additional Notes

Medical Conditions

Drug Allergies

Current Medications

GP signature ______________________ Referral date ______________________

For Hospital Use:

Date of referral received: ______________________

Date of appointment offered: ______________________

Reason patient did not accept first appointment offered: ______________________

Seen within guidelines:

Yes ☐

No ☐

☐ Urgent Referral (to be seen within 6 weeks)

☐ Routine Referral