**Suspected Connective Tissue Disease Referral Form**

**All referrals to the service are received via the Electronic Referral Service (eRS) – “Rheumatology” and mark referral “Suspected Connective Tissue Disease”**

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| **PATIENT NAME, ADDRESS AND TELEPHONE NO.** | **DATE OF BIRTH** | **NHS NO.** | **CURRENT DIAGNOSES** |
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| **Please select the urgency of the referral** |
| Routine □ | Urgent □ |

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| **What condition are you suspecting? (Please tick)** |
| SLE □ Myositis □Vasculitis □ Sjogrens □ | Systemic sclerosis □Behcets □Unspecified CTD □Other □ |

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| **Does the patient have any of the following features (Please tick)** |
| Rashes □ Photosensitivity □Hair loss □ Raynauds □Migraines □Skin tightening □History of thrombosis □ | Joint pain +/- swelling □Fatigue □Dry eyes and mouth □Systemic symptoms eg weight loss, fever, sweats, SOB, cough, GI symptoms □Other □ |

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| **Reason for referral:** |

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| **Relevant family history:** |

*Suggested investigations prior to referral; FBC, PV, CRP, U&E, Creat, LFT, TSH, Calcium, CPK, RF, Hep 2 ANA, C3, C4, Immunoglobulins, dipstick urine, CXR if appropriate.*

*Do not relay referral if investigations are negative*

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| **REFERRING GP’s NAME** | **SURGERY DETAILS**  | **DATE OF REFERRAL** |
|  |  |  |
| **GMC registration number** |  |