**Gout Referral Form**

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

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| **Please select the urgency of the referral** |
| Routine □ | Urgent □ |

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| **PATIENT NAME, ADDRESS AND TELEPHONE NO.** | **DATE OF BIRTH** | **NHS NO.** | **CURRENT DIAGNOSES** |
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| *Most cases of gout can be managed in primary care.*  |

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| **Refer to Rheumatology if any of the following features exist (please tick):**Polyarticular disease (>1 joint) □ |
| Uncertainty regarding diagnosis □Presence of progressive joint damage (clinically or radiologically) □Difficulty establishing or maintaining disease control □ |

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| **Please include the following information:**Symptom duration:  |
| Number of attacks per year:Risk factors eg alcohol, diuretics, renal disease, family history:Presence of tophi: |

*Please include past medical history and medication list*

*Suggested investigations: urate, CRP, PV, FBC, U&E, creat, LFTs, RF, Lipids (including triglycerides), xrays hands and feet.*

*Do not delay referral if blood tests or xrays are normal.*

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