**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** |
|  |  |  |
| **GMC registration number** |  |