**Inflammatory Arthritis Referral Form**

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT NAME, ADDRESS AND TELEPHONE NO.** | **DATE OF BIRTH** | **NHS NO.** | **CURRENT DIAGNOSES** |
|  |  |  |  |

|  |
| --- |
| ***Any person with suspected, persistent synovitis of undetermined cause should be referred for a specialist opinion*** |

|  |
| --- |
| Refer the patient URGENTLY if symptoms for **more than 6 weeks and less than 6 months** AND any of the following (please tick):  Swelling in 2 or more joints □ |
| Swelling in the small joints of the hands or feet □  Positive MCPJ or MTPJ ‘squeeze test’ □  Early morning stiffness >30 minutes □ |

|  |
| --- |
| Refer ROUTINELY if symptoms **more than 6 months** and any of the following (please tick):  Swelling in 2 or more joints □ |
| Swelling in the small joints of the hands or feet □  Positive MCPJ or MTPJ ‘squeeze test’ □  Early morning stiffness >30 minutes □ |

*If patient had symptoms for >6 months, but still felt urgent, please discuss via Consultant Connect prior to referral.*

|  |
| --- |
| **Other features that raise suspicion of early inflammatory arthritis (please tick):**  Constitutional symptoms □ |
| Presence of other features related to arthritis eg rash, painful red eyes or IBD □  Family history of autoimmune disease □  Family history of psoriasis □ |

|  |
| --- |
| **Please give details of the following aspects:**  Duration of symptoms: |
| Pattern of joint involvement/spinal symptoms:  Presence/duration of early morning stiffness:  Psoriasis/FH of psoriasis/IBD/iritis/uveitis:  Systemic symptoms eg weight loss, fever:  Examination findings: |

*Please include past medical history and medication list*

*Suggested investigations prior to referral: ‘Early arthritis’ profile (includes FBC, CRP, CE, LFT, Ca, RhF, urate, Hep2ANA), TSH, creatinine, bone profile, PV/ESR*

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

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