**Spondyloarthritis Referral Form**

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

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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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| Refer the following patients with suspected spondyloarthritis if they present with any of the following (please tick): |
| * Symptoms of inflammatory back pain:   + Age at onset <40 □   + Insidious onset □   + Improvement with exercise □   + No improvement with rest □   + Pain at night (with improvement on getting up) □ * Patients presenting with back pain and:   + History of iritis □   + History of psoriasis □   + History of inflammatory bowel disease □ |

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| 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: * Systemic symptoms eg weight loss, fever: * Examination findings: |

*Please include past medical history and medication list*

*Suggested investigations prior to referral: FBC, PV, CRP, U&E, creat, LFT, urate, HLAB27, Xray SI joints (if applicable).*

*Please don’t delay referral if bloods or xrays are normal.*

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