76 Grenville Street
Toronto, Ontario
M5S 1B2

Tel: 416-323-7723 Fax: 416-323-6304

CARDIOLOGY-RHEUMATOLOGY REFERRAL FORM

REFERRAL DATE: ____/____/______
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:____________ HCN:____________________________
Name:____
Sex:__________ Date of Birth:______/______/______
DD / MM / YYYY
Address:____
Telephone:_______________________________________

PLEASE NOTE:
- ***Do not** refer patients with pre-existing cardiovascular events (myocardial ischemia, coronary artery disease, angina, stroke, transient ischemic attack, heart failure, peripheral vascular disease, coronary re-vascularization etc.) or if they are already under the care of a cardiologist*
- *Completion of the rheumatology assessment form (pages 2 and 3) is required*

ADDITIONAL PATIENT INFORMATION

Preferred name: WCH Medical Record Number (*if known*):

Gender: Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: ____________

Is the patient aged 40-80 years: ☐ Yes ☐ No

Other insurance coverage (IFH, UHIP, etc.): ☐ Self-pay

Language spoken: Interpreter required: ☐ Yes ☐ No

Allergies:

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: ______________________________

Signature: ______________________________

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: ______________________________
Primary Care Provider Telephone: ______________________________

REASON FOR REFERRAL

RELEVANT MEDICAL HISTORY

Diagnosis of Rheumatoid Arthritis (RA), Psoriatic Arthritis (PsA), or Ankylosing Spondylitis (AS): ☐ Yes ☐ No

Ability to walk on treadmill: ☐ Yes ☐ No

CARDIOVASCULAR INVESTIGATIONS TO DATE *(please attach reports)*

CURRENT MEDICATIONS

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CARDIOLOGY-RHEUMATOLOGY REFERRAL FORM

RHEUMATOLOGY CASE REPORT FORM

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:____________ HCN:________________________

Name:____

Sex:__________ Date of Birth:_____/_____/______
DD / MM / YYYY

Address:_____________________________________

Telephone:___________________________________

DATE OF EXAM (DD/MM/YYYY):____________________

DEMOGRAPHICS

Gender: ☐ Male ☐ Female

Year of Birth (YYYY):

DISEASE CATEGORY

☐ Rheumatoid Arthritis (RA) ☐ Ankylosing Spondylitis (AS) ☐ Psoriatic Arthritis (PsA)

DISEASE DURATION	DISEASE CHARACTERISTICS		
Age at diagnosis in years (Arthritis): _________	**RA:**	Rheumatoid Factor (RF)	☐ Positive ☐ Negative ☐ Unknown
		Cyclic Citrullinated Peptide (CCP)	☐ Positive ☐ Negative ☐ Unknown
Age at diagnosis in years (Psoriasis): _________	**AS/PsA:**	Human Leukocyte Antigen B27 (HLA-B27)	☐ Positive ☐ Negative ☐ Unknown

EXTRA ARTICULAR FEATURES (EVER DIAGNOSED)

FOR RA PATIENTS				FOR AS/PsA PATIENTS	
Rheumatoid nodules	☐ No ☐ Yes	Scleritis/Episcleritis	☐ No ☐ Yes	Inflammatory Bowel Disease (IBD)	☐ No ☐ Yes
Interstitial lung disease	☐ No ☐ Yes	Felty Syndrome	☐ No ☐ Yes	Uveitis	☐ No ☐ Yes
Pericarditis	☐ No ☐ Yes	Other: Specify__________________		Psoriasis	☐ No ☐ Yes

JOINT SURGERY	☐ **No** ☐ **Yes** - **If Yes:** ☐ HIP ☐ KNEE ☐ OTHER: Specify __________________
RADIOGRAPHIC EROSIONS	☐ **No** ☐ **Yes** ☐ **UNKNOWN**
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) - CURRENT USE	☐ **No** ☐ **Yes** **RECORD NSAIDS CURRENTLY TAKEN:**

Diclofenac (Voltaren, Arthrotec)	☐ Daily ☐ prn	Indomethacin (Indocin)	☐ Daily ☐ prn
Ibuprofen (Advil, Midol, Motrin)	☐ Daily ☐ prn	Naproxen (Aleve, Naprosyn)	☐ Daily ☐ prn
Meloxicam (Mobicox)	☐ Daily ☐ prn	Celecoxib (Celebrex)	☐ Daily ☐ prn
Other: Specify ______________	☐ Daily ☐ prn		

SYSTEMIC STEROIDS - TO DATE	☐ **No** ☐ **Yes** **RECORD ALL STEROIDS EVER TAKEN:**

Oral Steroids: ☐ Current ☐ Past

If current use: ☐ Prednisone ☐ Prednisolone Dose: _________________ mg/Day

If current/past use: Total number of years ____________

WCH WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
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CARDIOLOGY-RHEUMATOLOGY REFERRAL FORM

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:____________ HCN:______________________

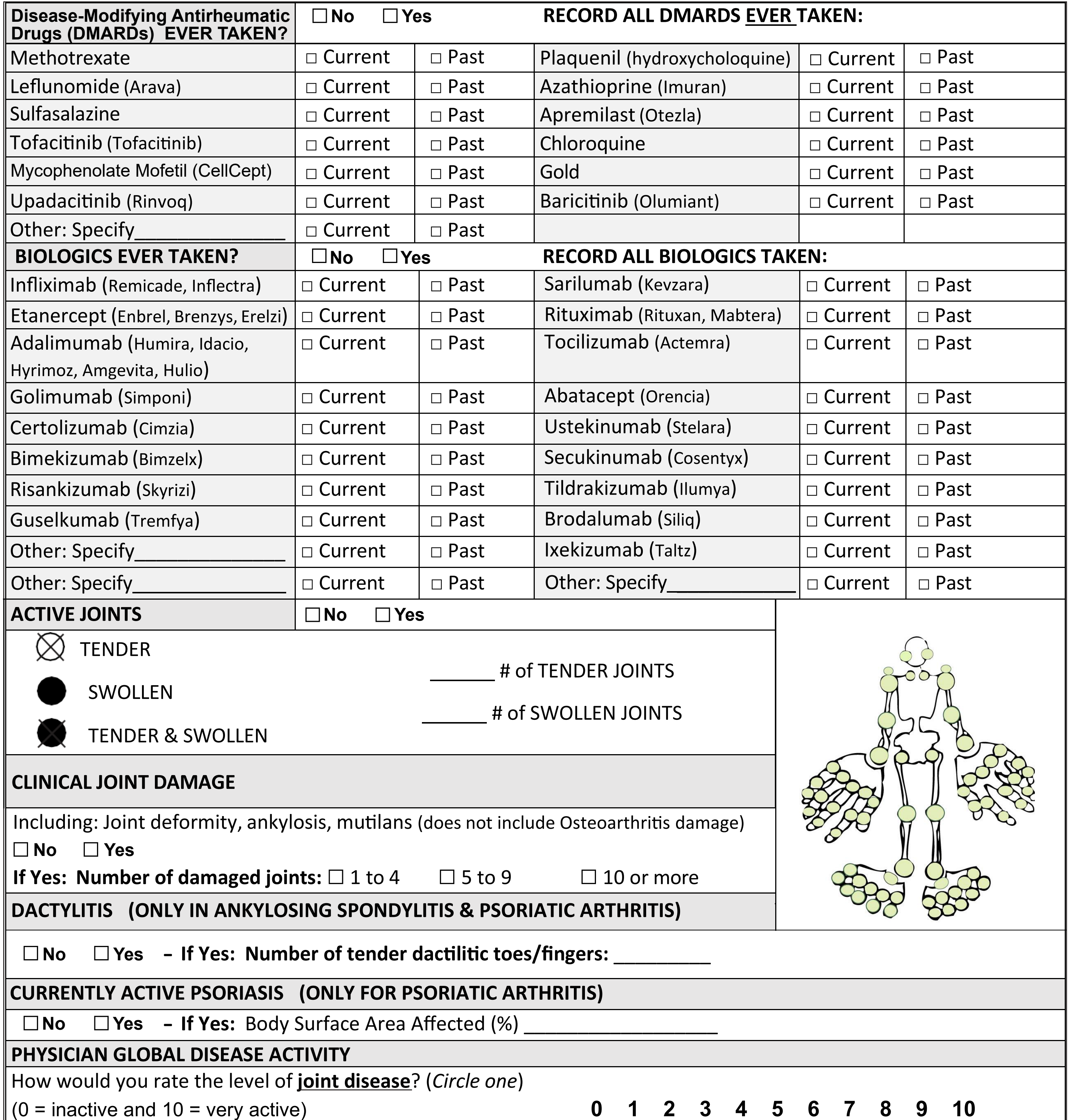
Name:______________________________________

Sex:__________ Date of Birth:_____/_____/_____
DD / MM / YYYY

Address:___________________________________

Telephone:_________________________________

RHEUMATOLOGY CASE REPORT FORM



Disease-Modifying Antirheumatic Drugs (DMARDs) EVER TAKEN?	☐ No ☐ Yes		**RECORD ALL DMARDS EVER TAKEN:**		
Methotrexate	☐ Current	☐ Past	Plaquenil (hydroxycholoquine)	☐ Current	☐ Past
Leflunomide (Arava)	☐ Current	☐ Past	Azathioprine (Imuran)	☐ Current	☐ Past
Sulfasalazine	☐ Current	☐ Past	Apremilast (Otezla)	☐ Current	☐ Past
Tofacitinib (Tofacitinib)	☐ Current	☐ Past	Chloroquine	☐ Current	☐ Past
Mycophenolate Mofetil (CellCept)	☐ Current	☐ Past	Gold	☐ Current	☐ Past
Upadacitinib (Rinvoq)	☐ Current	☐ Past	Baricitinib (Olumiant)	☐ Current	☐ Past
Other: Specify_______________	☐ Current	☐ Past			
BIOLOGICS EVER TAKEN?	☐ No ☐ Yes		**RECORD ALL BIOLOGICS TAKEN:**		
Infliximab (Remicade, Inflectra)	☐ Current	☐ Past	Sarilumab (Kevzara)	☐ Current	☐ Past
Etanercept (Enbrel, Brenzys, Erelzi)	☐ Current	☐ Past	Rituximab (Rituxan, Mabtera)	☐ Current	☐ Past
Adalimumab (Humira, Idacio, Hyrimoz, Amgevita, Hulio)	☐ Current	☐ Past	Tocilizumab (Actemra)	☐ Current	☐ Past
Golimumab (Simponi)	☐ Current	☐ Past	Abatacept (Orencia)	☐ Current	☐ Past
Certolizumab (Cimzia)	☐ Current	☐ Past	Ustekinumab (Stelara)	☐ Current	☐ Past
Bimekizumab (Bimzelx)	☐ Current	☐ Past	Secukinumab (Cosentyx)	☐ Current	☐ Past
Risankizumab (Skyrizi)	☐ Current	☐ Past	Tildrakizumab (Ilumya)	☐ Current	☐ Past
Guselkumab (Tremfya)	☐ Current	☐ Past	Brodalumab (Siliq)	☐ Current	☐ Past
Other: Specify_______________	☐ Current	☐ Past	Ixekizumab (Taltz)	☐ Current	☐ Past
Other: Specify_______________	☐ Current	☐ Past	Other: Specify_____________	☐ Current	☐ Past

ACTIVE JOINTS ☐ No ☐ Yes

⊗ TENDER
● SWOLLEN
⊗ TENDER & SWOLLEN

______ # of TENDER JOINTS
______ # of SWOLLEN JOINTS

CLINICAL JOINT DAMAGE

Including: Joint deformity, ankylosis, mutilans (does not include Osteoarthritis damage)
☐ No ☐ Yes
If Yes: Number of damaged joints: ☐ 1 to 4 ☐ 5 to 9 ☐ 10 or more

DACTYLITIS (ONLY IN ANKYLOSING SPONDYLITIS & PSORIATIC ARTHRITIS)

☐ No ☐ Yes – **If Yes: Number of tender dactilitic toes/fingers:** _________

CURRENTLY ACTIVE PSORIASIS (ONLY FOR PSORIATIC ARTHRITIS)

☐ No ☐ Yes – **If Yes:** Body Surface Area Affected (%) ________________

PHYSICIAN GLOBAL DISEASE ACTIVITY

How would you rate the level of **joint disease**? (*Circle one*)
(0 = inactive and 10 = very active) **0 1 2 3 4 5 6 7 8 9 10**