

Patient Name:
Address:

Contact Phone No.:
Date of Birth:
Health Card No.:

Referring Physician Name:
Address:

Phone No.:
Fax No.:
OHIP Billing No.:

Signature

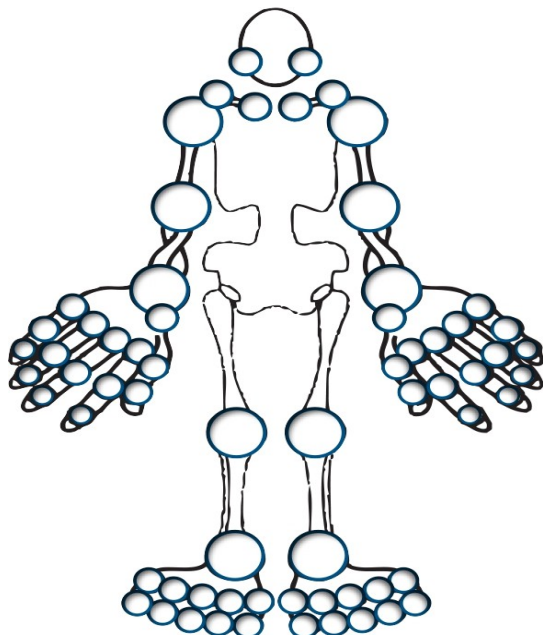
CARE DOES NOT ACCEPT REFERRALS FOR SECOND OPINION OR TRANSFER OF CARE.

Reason for Referral/ Suspected Diagnosis
(If Osteoporosis (OP) - please complete
OP Referral Form [HERE](#)):

☐ Joint Injection, if considered
Site: _____

Relevant medical history:
Append cumulative patient profile, if
available.

Indicate area of pain/swelling



MSK Assessments

**PLEASE NOTE THAT ALL PATIENTS WILL RECEIVE AN
MSK ASSESSMENT BY ONE OF OUR INTERDISCIPLINARY
HEALTH PROFESSIONALS AND WILL SEE A
RHEUMATOLOGIST ONLY IF DEEMED APPROPRIATE.**

History of Disease

How long has the problem been present?

☐ 6 weeks ☐ 6 weeks to 6 months ☐ > 6 months

Does the patient have morning stiffness?

30 minutes ☐ 30-60 minutes ☐ > 60 minutes

Is the patient limited in activities or had to stop work or school
due to THIS PROBLEM?

☐ Yes ☐ No

Additional Features: _____

☐ URGENT

(Within 1 week)

☐ SEMI-URGENT

(1-4 weeks)

☐ ROUTINE

(2-8 weeks)

Refer to Workshops/ Hand Splinting

- ☐ Inflammatory Arthritis (IA) Therapeutic Education Workshop
- ☐ Osteoarthritis (OA) Therapeutic Education Workshop
- ☐ Osteoporosis (OP) Therapeutic Education Workshop
(Please complete OP Referral Form [HERE](#))
- ☐ Fibromyalgia (FM) Therapeutic Education Workshop
- ☐ Hand Splinting

NOTE: Please attach copies of imaging reports, any relevant
consultations, treatments and surgical notes.