National Early Inflammatory Arthritis Referral Form

Irish Society for Rheumatology

This form must go to your selected Consultant and not to the Office of ISR

- *Please use this form if you believe the patient requires **rapid assessment of the symptoms / signs of inflammatory arthritis listed below**. (Otherwise please refer the patient in the usual way for your practice)*
- *Participating rheumatology centres will see patients with suspected inflammatory arthritis with a completed referral form within 6 weeks of receipt of referral. A list of participating centres is available on www.isr.ie*

Patient Details

Surname:

FirstName DOB:

Address:

Mobile No: Tel day:

Tel Evening: Hospital No. (if known):

First language: Interpreter required: Yes No

Gender: Male Female Wheelchair Assistance: Yes No

General Practitioner Details

Name:

Address:

Telephone: Fax:

Mobile:

Medical Council Registration No.:

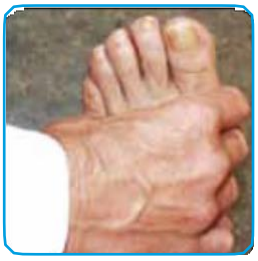
Duration of symptoms *(Please tick relevant box)* < 6 weeks < 6 months < 2yrs

Please tick if any of the below are positive

3 or more swollen joints

MCP /MTP involvement (squeeze test positive)

Early Morning Stiffness > 30 minutes



Personal or family Hx of: Psoriasis Colitis Uveitis

Personal Hx of: Back Pain or Stiffness* Recent Infective Illness

*If back pain is the only feature you have identified, the Ankylosing Spondylitis Advisory Council guidance of when to refer back pain will help you further. Please logon to www.isr.ie to download the Back in Action GP Information Booklet.

Investigations* – the following blood tests should be done in all patients with suspected inflammatory arthritis:
FBC, ESR, CRP, Rheumatoid Factor, Anti CCP (where available), ANA, U&E, LFTs, Urate

ESR	Tick if completed	Results:
CRP	Tick if completed	Results:
Rheumatoid Factor	Tick if completed	Results
Anti CCP	Tick if completed	Results

*Please append relevant test results

Please fill in relevant sections below (or provide this information in the form of a letter)

Referring Notes

Medical Conditions

Drug Allergies

Current Medications

Referral Centre

Consultant Name:

Address:

Fax:

Office Number:

Email:

GP signature _____ Referral date _____

For Hospital Use:

Date of referral received: _____

Date of appointment offered: _____

Reason patient did not accept first appointment offered: _____

Seen within guidelines:

Yes ☐

No ☐

☐ Urgent Referral (to be seen within 6 weeks)

☐ Routine Referral