Referral to Early Arthritis Clinic Mater Dei Hospital

NAME	
ADDRESS	
ID NUMBER	
TEL. NO.	

Rapid referral to rheumatologist advised in the event of clinical suspicion of RA, which may be supported by the presence of any of the following

- **≥3 swollen joints** Yes / No
- **MTP/MCP involvement** Yes / No
- **Morning stiffness of ≥30 minutes** Yes / No

Symmetrical symptoms? Yes / No

Good response to NSAIDS? Yes / No

Family history of rheumatoid arthritis? Yes / No

Duration of symptoms

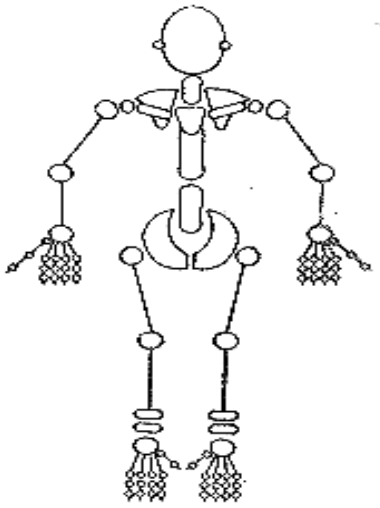
Date of referral

Drug history

Relevant results if available	
Hb	Cr
WCC	RA
Plts	ANA
ESR	Anti CCP
CRP	

*Incompletely filled forms will not be considered in the vetting process. It is the responsibility of the referring doctor to ensure that all requested information is documented .

Right



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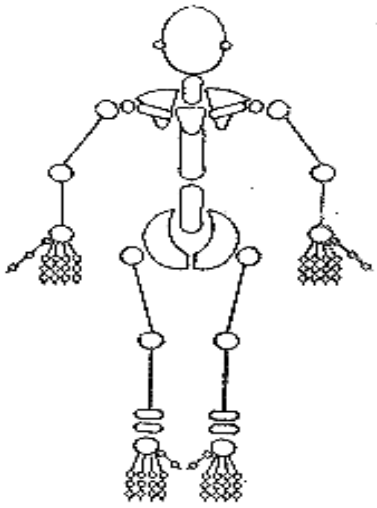

Symptoms	
Pain	P
Swelling	S
Redness	R

Signs	
Swelling	S
Tenderness	T

Please note your impressions on the diagrams provided.

Free script	

DOCTOR	
Registration number	
Contact Number	
E-mail	
Signature	