REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**RHEUMATOLOGY CLINIC**

Template for correspondence about patient with

**INFLAMMATORY ARTHRITIS - NEW OR SUSPECTED DIAGNOSES ONLY**

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| **SEND TO**: Dr Jacob Ijdo (Director of Rheumatology)Outpatient Access and Scheduling CentreFax: 07 5687 4497  **OR****Secure transmission service via Medical Objects or****Healthlink to****QHEALTH,GOLD COAST HEALTH Outpatients****Outpatient Bookings and Referrals** | **FROM** **Doctors Name:** **Practice Name:****Practice Address:****Phone:** **Fax:** **Email:** **Provider Number:**  |

Dear Dr Ijdo

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

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| **Gender:** **Address:** **Home Ph:** **Mobile Ph:** **Medicare Number\*:** (\*Medicare ineligible patients will incur a consultation fee) | **Next of Kin/Alternative Contact:** **Next of Kin/Alternative Contact Ph:** **Does patient identify as Aboriginal and/or Torres Strait** **Islander:** **Interpreter required:** **If yes, specify language:**  |

**SECTION 2 Reason for referral and additional clinical information**

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| What is the reason for this referral:Please provide provisional diagnosis (if available):Please include any symptoms and date of onset (if known):**Paste or type relevant history, clinical examination findings and treatment to date if required** |

**SECTION 3 Mandatory clinical information**

Inflammation for >6 weeks in >1 joint:

If yes, please specify:

Morning joint stiffness for >30 min:

Duration of symptoms <1 year:

MCP and/or MTP positive squeeze test:

Family history of inflammatory joint disease:

If yes, please specify:

Beneficial response to NSAID:

If yes, please specify:

History of psoriasis, colitis, uveitis:

If yes, please specify:

**SECTION 4 Investigations**

Please indicate whether the following pre-requisite investigations have been undertaken in order for this referral to be processed and attach the results. In addition, please also attach any investigation results you consider to be relevant.

 Scan results: **Please instruct patient to bring relevant imaging/films to clinic**

**ESR/CRP**:

**FBC**:

**E/LFTs**:

**Autoimmune screen (Rheum factor and/or anti-CCP)**:

**XR of affected joint (if applicable)**:

**SECTION 5 Duration of referral**

Please indicate how long you would like your referral to remain valid:

[ ]  12 months

[ ]  Indefinite

Indefinite referrals do not expire until the patient has been discharged by the hospital service. When referrals expire, there is an expectation that the referring GP or another GP will review the care of the patient. If the patient still requires specialist care, the GP will then have to request a referral continuation.

**SECTION 6 Social factors and impact on the patient**

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| *Consider the impact on employment/education; activities of daily life; ability to care for others; personal safety/frailty; other factors.* ***Please paste or type relevant information.*** |

**SECTION 7 Medical history including co-morbidities and previous surgical interventions**

**Alcohol Status/History:**

**Smoking Status/History:**

**Medical History:**

**Comorbidities:**

**Previous Procedures:**

**Allergies/Adverse Reactions:**

**Current prescribed medications:**

**SMOs/VMOs in Specialist Service**

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| Dr Jacob Ijdo (Director) (SMO) | Dr Julien de Jager (VMO) | Dr Jennifer Ng (SMO) |
| Dr Sateesh Shankaranarayana (VMO) | Dr Shunil Sharma (VMO) | Dr Jeffery Tsai (VMO) |