Dartmouth Health

Dartmouth Hitchcock Medical Center

Phone: (603) 650-8622
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Rheumatology

Has patient previously seen a Rheumatologist? ❑ Yes ❑ No If yes, please provide notes from that provider.

❑ **Inflammatory Arthritis (Rheumatoid Arthritis, Psoriatic Arthritis)**

Exam shows swollen small joints (hands, feet, etc.)

Exam shows swollen large joints (knees, shoulders, etc.) } X-ray of affected joint(s)

Nail pitting: ❑ Yes ❑ No

RF+: _____ ❑ Elevated CRP: _____

CCP+: _____ ❑ Elevated ESR: _____

Other: _____

❑ **Lyme Disease:**

# of antibiotic courses: _____

Which anibiotic: _____

How was it diagnosed: _____

Other: _____

❑ **+ANA** (please provide clinical symptoms or lab abnormalities)

- ❑ Pleurisy
- ❑ Pericarditis
- ❑ Cytopenias
- ❑ +dsDNA
- ❑ AM stiffness >1 hour
- ❑ Proteinuria
- ❑ Tight Skin
- ❑ Joint Pain
- ❑ Kidney Disease (Nephrolo -gy referral & biopsy)
- ❑ Malar Rash
- ❑ Recurrent Fevers
- ❑ Swollen Joints
- ❑ Raynaud's
- ❑ Photosensitivity
- ❑ Sicca Symptoms
- ❑ ENA
- ❑ Rash (Derm referral & biopsy)

Other: _____

Continued ➔

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❑ **Ankylosing Spondylitis (Spondyloarthropathies)**

❑ Prominent nocturnal pain/awakening at night
❑ AM Stiffness >1 hour
❑ Elevated ESR or CRP: _____
❑ If positive & with back pain: SI and lumbar spine x-rays
❑ If negative & with back pain: MRI of SI & lumbar spine
❑ Responsive to NSAIDs
❑ HLA-B27+: _____

Other: _____

❑ **Giant Cell Arteritis/PMR**

❑ Onset of symptoms: _____
❑ Steroid started: When? _____
❑ Temporal artery biopsy done? ❑ Yes ❑ No
❑ Elevated ESR/CRP: _____
❑ Vision loss or changes (if yes, send to Ophthalmology or Emergency Room)

Other: _____

❑ **Systemic Vasculitis**

❑ Lungs ❑ Kidneys (Nephrology referral, biopsy) ❑ Nervous System (Neurology referral)
❑ Skin ❑ Other: _____

Onset: _____
Abnormal labs: _____
Any other concerns: _____

❑ ANA ❑ ANCA ❑ Urinalysis

❑ **Crystalline Arthritis (Gout, Pseudogout)**

❑ Joints involved: _____
❑ X-ray of affected joints
❑ Therapies already tried: _____
❑ Crystals previously documented: ❑ Yes ❑ No other: _____

❑ **Osteoarthritis**

❑ Please list specific goals: confirm dx, joint injections, other: _____

❑ **Sjogren's Syndrome**

❑ ANA+: _____
❑ La+: _____
❑ Lip biopsy
❑ Ro+: _____
❑ Eye evaluation
❑ Medications: _____

_____