Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

The Early Arthritis Clinic
Patient Referral Form

Telephone: 905-883-1212 / 905-832-4554 Ext.2004 **Fax: 905-883-0772**

Patient Name: *(Print Last, First)*

Address: # *Street:* *Apt:* *City/Town* *Province* *Postal Code*

Health Card Number: Version Code: Date of Birth: *(dd/mm/yyyy)*

Primary Number: ( ) ☐ Cell ☐ Home ☐ Work ( )

Secondary Number: ( ) ☐ Cell ☐ Home ☐ Work ( )

Emergency Contact Name: Relation: Telephone Number: ( )

Physician Information

Referring Physician Name: *(Please Print)*________________ Referring Physician Signature ____________

Referring Billing Number: ________________

Address: ____________ City: ____________ Postal Code: ____________

Telephone Number: ____________ Fax: ____________

Family Physician same as above ☐ Yes ☐ No If no, please provide information below

Family Physician Name: ________________

Address: ____________ City: ____________ Postal Code: ____________

Telephone: ( ) ____________ Fax Number: ( ) ____________

Reason for Referral

Three or more swollen joints ☐ Yes ☐ No
OR
Morning Stiffness of 30 minutes or more ☐ Yes ☐ No
OR
Metacarpal Joint/Metatarsal Phalangeal Joint Involvement ☐ Yes ☐ No

Additional Section

Please advise patient to bring a copy of recent Lab Tests and Radiographic Reports.
The patient will be contacted directly with a Clinic appointment date and time.

Lab Tests Attached : ____________ Completed Date: ____________ *(dd/mm/yyyy)*

Radiographic Reports Attached: ____________ Completed Date: ____________ *(dd/mm/yyyy)*