CArE Centre of Arthritis Excellence
A Regional Program… A National Resource

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The Centre of Arthritis Excellence (CArE) – Referral Form

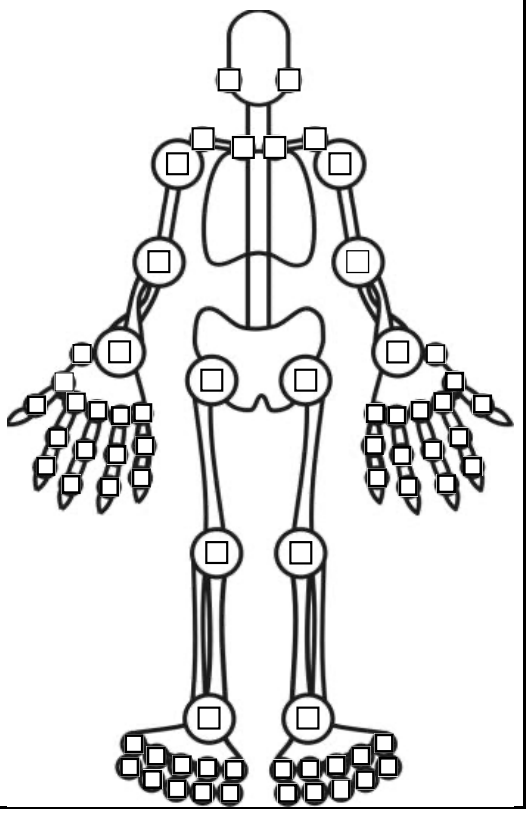
PLEASE NOTE THAT A REFERRAL TO CArE DOES NOT GUARANTEE ASSESSMENT BY A RHEUMATOLOGIST AND TRIAGE WILL BE DELAYED FOR INCOMPLETE REFERRALS

Please **ensure ALL fields below have been completed** and additional relevant investigations/reports attached, including most recent **Bone Mineral Density results for osteoporosis** referrals

Patient Name - First:	Last:	
Date of Birth (MM-DD-YYYY):	Age:	Gender:
Address:	City/Prov.:	Postal Code:
Phone Number:	Email:	
Health Card Number (include version code):		

Reason for Referral/Clinical Question:

Indicate the areas of pain/swelling:



Is participation in daily activities impacted by illness? ☐ Yes ☐ No

Duration of symptoms: ☐ <6 mos ☐ 6-12 mos ☐ Years (#):

Past Medical History (Please attach additional pages as needed, incl. bloodwork and imaging):

Current Medications (Please attach list/additional pages as needed):

Family History of Inflammatory/Auto-Immune Condition (i.e. Psoriasis, IBD, RA): ☐ Yes ☐ No

Please list any accommodations required for this patient to receive care (i.e. mobility device, service animal, communication support):

Referring Provider:	Billing Number:
Phone Number:	Fax Number:
Signature:	Date (MM-DD-YYYY):

PLEASE FAX COMPLETED REFERRAL FORM AND ACCOMPANYING DOCUMENTS TO:
(905) 235-0332

Updated July 2024