Health Plus
MULTISPECIALTY MEDICAL CLINIC

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Appointment Date: _____Time: _____

RHEUMATOLOGY REFERRAL

PATIENT INFORMATION			
Patient's Last Name:	First Name:	Middle Name:	Sex: ❑ M ❑ F
Date of Birth:	OHIP no:		Version Code:
Patient's Address:			
City:	Province:	Postal Code:	
Home Phone no:	Mobile Phone no:		

REASON FOR REFERRAL

- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Psoriatic Arthritis
- ☐ Reactive Arthritis
- ☐ Enteropathic Arthritis
- ☐ Systemic Lupus Erythematosus
- ☐ Sjogren's Syndrome
- ☐ Antiphospholipid Antibody Syndrome
- ☐ Other (Specify) _____

Diagnosis:

REFERRAL INFORMATION	
Referring Physician:	Date:
Physician Signature:	Billing no: