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*Date of referral: _____ (yyyy/mm/dd)

Patient Name: _____ D.O.B. (yyyy/mm/dd) _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Health Card #: _____ Tel #: _____ Alternate #: _____

Referring Physician: _____ Signature: _____

Billing#: _____ CPSO#: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Tel #: _____ Fax: _____

Please indicate which clinic you are referring to:

- Rapid access joint injection clinic*
- New/ suspected arthritis clinic
- Fibromyalgia assessment clinic
- Rheumatologic triage clinic

*If you are referring to the rapid access joint injection clinic, indicate which joint(s):

RightShoulder	Right GTBursa	
Left Shoulder	Left GT Bursa	
Right Elbow	Right Knee	
Left Elbow	Left Knee	
Right Wrist	Right Ankle	
Left Wrist	Left Ankle	
IP/MCP/CMC	MTP(s)	

Indicate the most likely / suspected diagnosis: _____

Relevant History: (attach separately)

Are you practicing within a FHO/FHN model? Y N

List any previously ordered labs:(attach reports separately)_____

List any previously ordered imaging: (attach reports separately)_____

The referring physician's office will be contacted with the date and time of the appointment after triage of this referral. Upon receipt of this referral, per CPSO guidelines your patient will be contacted directly to schedule her/his appointment.