



Please fax completed form to (865) 246-7568
Specialty Clinic-East Tennessee Children's Hospital (865) 541-8830
Please include patient demographics and copy of insurance card(s)

Rheumatology Clinic Referral

Patient's full name \_\_\_\_\_ DOB: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Please circle the patient's symptoms below:

- Joint pain, Joint stiffness, Joint swelling, Fever, Rash, Muscle pain, Muscle tenderness, Weakness, Psoriasis, Alopecia, Oral ulceration, Raynaud's, Depression, Other: \_\_\_\_\_

What is the duration of symptoms? \_\_\_\_\_

Have you personally examined the patient for these complaints? [ ] Yes [ ] No

If yes, have you observed any of the following (circle):

- Joint swelling, Joint tenderness, Muscle tenderness, Motor weakness, Raynaud's, Oral ulceration, Rash, Psoriasis, Fever > 2 weeks in the absence of infection, Other: \_\_\_\_\_

Circle any lab abnormalities that are present:

- Proteinuria (1+or>), Hematuria, ESR>25mm/hr, Elevated CRP, + RA factor, + CCP antibody, +ANA >/=1:160, + DNA Antibodies, Elevated CPK, Elevated Aldolase, WBC <3.0, Platelets < 100K, Hct. <35%, + Coombs, + lupus anticoagulant, + anticardiolipin AB, Other: \_\_\_\_\_

Are there any radiographic abnormalities? [ ] Yes [ ] No

If yes, describe: \_\_\_\_\_

What treatments have been employed to treat the symptoms (circle)?

- OT analgesics, NSAIDS, Steroids, Physical therapy, Other comments: \_\_\_\_\_

Physician's signature

Date/Time