**Surrey and Sussex Healthcare NHS Trust**

**Early Inflammatory Arthritis Clinic (EAC) Referral Form**

**Please refer patients by completing this form and sending it via ERS**

|  |  |
| --- | --- |
| **Patient Information** | **Practice Information** |
| Full Name: | Referring GP |
| Address: | Practice Address |
| NHS Number: | Practice Phone number: |
| Hospital number: | Practice Email address: |
| DOB: Gender: |  |
| Contact Phone Number: |  |

* Please **only** use this referral form if the patient **clinically has inflammatory arthritis affecting more than one joint**.
* **Please send all other referrals to a general Rheumatology clinic in the usual way**
* Please refer patient for appropriate blood tests +/- x-rays prior to sending referral

Please answer each statement below with an X in either Yes or No. **MUST have Yes for 1 AND any TWO of 2-5 to make a referral to the Early Inflammatory Arthritis Service.**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Yes | No |
| 1 | Synovitis – Inflammation (Hot, tender & swelling) of the MCPs, PIPs and MTPs or 2 or more large joints  |  |  |
| 2 | Joint pain for more than 4 weeks and less than 6 months? |  |  |
| 3 | Involvement of the hands, wrists and feet |  |  |
| 4 | Positive RF and/or Anti CCP |  |  |
| 5 | Raised ESR and CRP |  |  |

Please include relevant blood tests, either by filling in below table or attaching relevant practice summary. Please request these **PRIOR** to referring patients to EAC.

|  |  |
| --- | --- |
| **Test** | **Result** |
| FBC |  |
| U&Es |  |
| LFTs |  |
| CRP |  |
| ESR |  |
| Urate |  |
| Immunology if known |  |

Please document relevant past medical history, drug history and family & social history in this space or please attach relevant practice summary:

**Incomplete information will result in the referral being rejected and returned for completion of required fields.**