**Referral pathway to the Early Inflammatory Arthritis Service (EIA Service) - 3 week wait**

Please complete the following **in full**, save and attach to e-referral **including as much clinical detail** as possible. Incomplete forms will be returned to the GP. NOT to be used for patients with established diagnoses of rheumatoid/inflammatory/osteoarthritis or fibromyalgia.

|  |  |
| --- | --- |
| Patient Name: | GP Name: |
| NHS Number: | GP Practice: |
| Date of Birth: | GP Practice Telephone No.: |
| Patient Telephone Number: | GP Practice Email: |
| Date of referral: |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Yes | No |
| 1 | Patient has suspected joint swelling for 4 weeks or more\*, **but less than 6 months (refer to general rheumatology clinic if longer history)** |  |  |
| 2 | Patient has swelling in 3 or more joints? |  |  |
| 3 | Patient has swelling in the small joints of the hands or feet? |  |  |
| 4 | Patient has raised inflammatory markers |  |  |
| 5 | Early morning stiffness EMS >30 mins |  |  |

**Additional features to raise suspicion of inflammatory arthritis (please complete with X):**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Yes | No |
| 6 | Constitutional symptoms? e.g., weight loss, anorexia or fatigue |  |  |
| 7 | Presence of other features related to arthritis, e.g., rash, painful red eyes or inflammatory bowel disease? |  |  |
| 8 | Family history of autoimmune disease? |  |  |
| 9 | Family history of psoriasis? |  |  |

|  |  |  |
| --- | --- | --- |
| 10 | Approximate date of symptom onset: |  |

**Suggested investigations to be requested by GP prior to/at time of referral (please complete with X):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Normal | Abnormal (can give details) | Pending |
| 11 | FBC, U&E, LFTS |  |  |  |
| 12 | CRP |  |  |  |
| 13 | Rheumatoid factor (RF) |  |  |  |
| 14 | Anti CCP antibody |  |  |  |
| 15 | TFTs |  |  |  |
| 16 | Xrays- hands and feet |  |  |  |
| 17 | Other relevant\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**18 Please write relevant clinical details and medical history here or attach a referral letter:**