**Suspected Connective Tissue Disease Referral Form**

**All referrals to the service are received via the Electronic Referral Service (eRS) – “Rheumatology” and mark referral “Suspected Connective Tissue Disease”**

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT NAME, ADDRESS AND TELEPHONE NO.** | **DATE OF BIRTH** | **NHS NO.** | **CURRENT DIAGNOSES** |
|  |  |  |  |

|  |  |
| --- | --- |
| **Please select the urgency of the referral** | |
| Routine □ | Urgent □ |

|  |  |
| --- | --- |
| **What condition are you suspecting? (Please tick)** | |
| SLE □  Myositis □  Vasculitis □  Sjogrens □ | Systemic sclerosis □  Behcets □  Unspecified CTD □  Other □ |

|  |  |
| --- | --- |
| **Does the patient have any of the following features (Please tick)** | |
| Rashes □  Photosensitivity □  Hair loss □  Raynauds □  Migraines □  Skin tightening □  History of thrombosis □ | Joint pain +/- swelling □  Fatigue □  Dry eyes and mouth □  Systemic symptoms eg weight loss, fever, sweats, SOB, cough, GI symptoms □  Other □ |

|  |
| --- |
| **Reason for referral:** |

|  |
| --- |
| **Relevant family history:** |

*Suggested investigations prior to referral; FBC, PV, CRP, U&E, Creat, LFT, TSH, Calcium, CPK, RF, Hep 2 ANA, C3, C4, Immunoglobulins, dipstick urine, CXR if appropriate.*

*Do not relay referral if investigations are negative*

|  |  |  |
| --- | --- | --- |
| **REFERRING GP’s NAME** | **SURGERY DETAILS** | **DATE OF REFERRAL** |
|  |  |  |
| **GMC registration number** |  |