**Spondyloarthritis Referral Form**

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

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

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| **PATIENT NAME, ADDRESS AND TELEPHONE NO.** | **DATE OF BIRTH** | **NHS NO.** | **CURRENT DIAGNOSES** |
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| Refer the following patients with suspected spondyloarthritis if they present with any of the following (please tick): |
| * Symptoms of inflammatory back pain:
	+ Age at onset <40 □
	+ Insidious onset □
	+ Improvement with exercise □
	+ No improvement with rest □
	+ Pain at night (with improvement on getting up) □
* Patients presenting with back pain and:
	+ History of iritis □
	+ History of psoriasis □
	+ History of inflammatory bowel disease □
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| Please give details of the following aspects: |
| * Duration of symptoms:
* Pattern of joint involvement/spinal symptoms:
* Presence/duration of early morning stiffness:
* Psoriasis/FH of psoriasis/IBD/iritis:
* Systemic symptoms eg weight loss, fever:
* Examination findings:
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*Please include past medical history and medication list*

*Suggested investigations prior to referral: FBC, PV, CRP, U&E, creat, LFT, urate, HLAB27, Xray SI joints (if applicable).*

*Please don’t delay referral if bloods or xrays are normal.*

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