Please fax completed form to ***865-541-8405***

Specialty Clinic-East Tennessee Children's Hospital 865-541-8830

Please include patient demographics

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

Form No. 32002 (11/19)