Division of Rheumatology, Dept. of Medicine & MSK Program
M1-401 – 2075 Bayview Avenue, Toronto, ON, Canada M4N 3M5 Tel 416.480.4580 Fax 416.480.4233

Request for Rheumatology Consultation

Date: _____

Last Name First Middle Initial | Telephone | Alternate

Address | Date of Birth | OHIP

Referring MD: | **Ref#:**

Address | Telephone | Fax

Reason for Referral:

Type of referral: New referral Re-referral 2nd opinion
MSK specialist seen previously (Date: *Name:*)

Past Medical History:

Medications

Allergies:

Relevant investigations (important for triaging):

Bloodwork *(Attached if available)*
Diagnostic imaging *(Attached if available)*
Cumulative Patient Profile and Consultation letters *(Attached if available)*
Is this patient involved in a WSIB/insurance/legal claim? Yes No

Referring Physician's Signature | Date

Please mail or fax referral form to:

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