



REFERRAL TO RHEUMATOLOGY DAY PROGRAM

- Inflammatory Arthritis** (i.e. Rheumatoid Arthritis; Psoriatic Arthritis)
Please specify _____
- Osteoarthritis**
Please specify region (s) _____

PATIENT DEMOGRAPHICS

Patient Name: _____
Address: _____
Phone Number: Home: _____ Work: _____
Date of Birth: _____

Other Medical Conditions: _____

ADMISSION CRITERIA CHECKLIST

(Please check each box to ensure patient meets all criteria)

General Criteria:

- patient must be able to attend two week program from 9:00 to 4:00 Monday to Friday
- patient must be willing to attend sessions offered by social work, psychology, occupational therapy, physiotherapy and medicine
- patient must be open to learning self-management strategies to managing their symptoms
- patient must be able to work collaboratively within a group setting

Inflammatory Arthritis Criteria:

- diagnosis has been confirmed by a rheumatologist
- copy of most recent rheumatology consultation note is included.

Osteoarthritis Criteria:

- program not appropriate for individuals with chronic lower back pain

Signature of Physician: _____ **Date :** _____

Please Print Physician Name: _____

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