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## Rheumatology, Immunology & Allergy Referral

Date of Referral:	
<b>Patient Name:</b>	<b>Referring Physician/NP:</b>
Date of Birth:	Billing Number:
Address:	Address:
Phone Number:	Phone Number:
Cell Number:	Fax Number:
HCN:	Family Physician:
Email:	Email:

### Suspected Diagnosis:

<input type="checkbox"/> <b>Emergent:</b> e.g. Vasculitis, Giant Cell Arteritis, Organ-Threatening Connective Tissue Disease	
<b>Autoimmune/Inflammatory:</b> <input type="checkbox"/> Connective Tissue Disease (e.g., SLE, Sjogren's, Scleroderma, Myositis, MCTD) <input type="checkbox"/> Polymyalgia Rheumatica <input type="checkbox"/> Non-Emergent Vasculitis <input type="checkbox"/> Autoinflammatory Disease <input type="checkbox"/> Gout/Pseudogout  <b>Immunodeficiency</b> <input type="checkbox"/> Recurrent Infections (e.g., IgQ (G.A.M.E))	<b>Allergy:</b> <input type="checkbox"/> Environmental Testing (Rhinitis, Rhinosinusitis, Asthma) <input type="checkbox"/> Suspected Food Allergy <input type="checkbox"/> Urticaria <b>*Please provide additional information below (possible allergens, possible reactions, etc).</b> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>

### Lab Tests, Diagnostic Imaging, and Investigations and other Recommendations

**Emergent:** Please send available test results and do not delay referral for additional tests

<b>Autoimmune/Inflammatory</b> <ul style="list-style-type: none"><li>• <b>Connective Tissue Disease</b><ul style="list-style-type: none"><li>○ ANA, ENA, Anti-DNA</li><li>○ CBC, ESR, CRP, Cr, CK</li><li>○ C3, C4, Uric Acid</li></ul></li><li>• <b>Gout/Pseudogout</b><ul style="list-style-type: none"><li>○ Ca, Mg, Phos, Alb, Uric Acid, PTH, TSH</li><li>○ X-rays of effected areas.</li></ul></li></ul>	<b>Allergy</b> <ul style="list-style-type: none"><li>○ CBC, Total IgE</li></ul>
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\*For our EIA (PsA, RA, Inflammatory Back Pain) please refer to our Early Inflammatory Arthritis Clinic

Referral form \*

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