



**The Rheumatology Clinic** has established the following standardized criteria for referrals. To avoid delay in appointment scheduling, please ensure that all supporting information for the pre-determined outcome and/or condition is included with the Outpatient Referral Form **prior** to requesting the referral. Please mark the appropriate box(s) as indicated.

- 1. Fibromyalgia-Consider if total body pain. Fibromyalgia is currently still a diagnosis of exclusion but involves tenderness to palpation of both upper and lower extremities bilaterally and in axial skeleton area. The best treatment is sound sleep with good sleep hygiene and aerobic exercise at least 30 minutes 5 days per week.**

**Please attempt the following and document before referring to us for further evaluation.**

- Examination documenting FMS tender points (11/18 needed for diagnosis)
- Check TSH, Vit D (25-OH), ESR to rule out other etiologies of diffuse aching pain. If ESR elevated, get SPEP/UPEP also
- Counseling on sleep hygiene and trial of all of the following sleep medications as needed: Trazadone, Temazepam, Zolpidem, and Eszopiclone
- Counsel patient on regular aerobic exercise (with pool exercise optimally if other medical conditions prevent regular weight bearing exercise). We recommend starting with 5 minutes daily and advancing to goal of 30 minutes 5x/week (to raise heart rate). Arthritis Foundation has free pool therapy programs for patients all over the Inland Empire-patients can call (909)320-1540 for more information
- SSNRI: Cymbalta, Effexor, or Savella trial
- Gabapentin, titrated slowly to dose of 1200mg PO TID or adverse reaction documented. If not able to tolerate, can try:
  - Lyrica 75mg PO BID and titrate to max dose of 150mg PO TID. Lyrica needs to be tapered down over 7 days prior to d/cing
  - Amitriptyline 25mg PO qhs to be advanced up to 100mg PO qhs as tolerated
  - Tramadol to max dose of 100mg PO QID

- 2. Suspected Rheumatoid Arthritis:**

**Please obtain the following labs/x-rays:**

- Anti-CCP (we use this instead of the Rheumatoid Factor (RF) which is non-specific)
- ESR, CRP (always elevated in RA patients)
- CBS, CMP

- Arthritis series including AP bilat hands, AP Feet, AP standing knees, AP pelvis; 2 views shoulders, elbows and ankles; cervical spine flexion and extension, lumbar spine AP and lateral views
- Notes documenting joint swelling and morning stiffness lasting >1hour

### 3. Suspected SLE:

#### Please obtain the following labs:

- CBC, CMP
- UA-Clean catch midstream IMPORTANT
- ESR, CRP
- ANA TITERS, refer only if >1:160 (Do NOT order ANA as “Reflex”)
- Anti-dsDNA Ab
- Anti-Smith Ab
- SSA/Ro and SSB/La
- Anti-RNP
- Note documenting symptoms that are leading you to suspect SLE (pt reports h/o is no enough unless already on DMARDs)

*Criteria for SLE include:*

1. Malar Rash
2. Discoid Rash
3. Photosensitivity
4. Oral ulcers (oral or nasopharyngeal)
5. Arthritis (nonerosive, involving 2 or more joints)
6. Serositis (pleuritis + pleuritic pain or rub, OR pleural effusion, OR pericarditis, OR pericardial effusion)
7. Renal disorder (persistent proteinuria >0.5 grams per day OR cellular CASTS)
8. Neurologic disorder (seizures OR psychosis)
9. Hematologic disorder (*hemolytic anemia w/reticulocytosis* OR *Leukopenia* <4,000 on two or more checks OR *Lymphopenia* <1,5000 on two or more checks OR *Thrombocytopenia* < 100,000)
10. Positive anti-nuclear antibody (in absence of drugs known to be associated with “drug-induced SLE”) EG. Procaine Amide or Hydralazine
11. Anti-dsDNA or Anti-Smith antibody (OR antiphospholipid antibody OR false positive serologic test for syphilis known to be + for at least 6 months and confirmed by fluorescent Treponema pallidum antibody absorption test)