ENROLLMENT NOTIFICATION FORM

Date of Baseline Assessment: _____/______/_______(dd/mm/yyyy)

PATIENT INFORMATION

Name: _______________________________________ **Gender:** ☐ **Male** ☐ **Female**

Address:___________________________________ **City:** ___________________ **Prov: ON PC:**____________

Telephone: _____________ **DOB:** ____/____/______ (dd/mm/yyyy) **Health Card Number:** _____/______/_____ v____

► **Refer to The Arthritis Society Arthritis Rehabilitation & Education (AREP) Program:** ☐ No ☐ Yes

RHEUMATOID ARTHRITIS HISTORY

► **Rheumatologist Diagnosis of RA:** ☐ Yes ☐ No ► **Date of Diagnosis:** ☐ Year ______ ***or*** ☐ Age _____ ☐ Unknown

► **Active RA** (≥1 swollen joint) ☐ Yes ☐ No

► **Rheumatoid Factor:** ☐ Positive ☐ Negative ☐ Unknown

► **Anti-CCP:** ☐ Positive ☐ Negative ☐ Unknown

► **Extra-Articular Features:** ☐ Absent ☐ Nodules ☐ Interstitial Lung Disease ☐ Ocular ☐ Neurologic ☐ Felty's ☐ Vasculitis ☐ Sjogren's ☐ Unknown ☐ Other:______________________

RA MEDICATION HISTORY and TREATMENT CHANGES BEING MADE TODAY

► **Has patient ever had DMARD therapy?** ☐ No ☐ Yes ☐ Unknown

► **Has patient ever had biologic therapy?** ☐ No ☐ Yes ☐ Unknown (i.e., RCT) ☐ Indication other than RA

Previous Biologics	Start Date mm/yy	Stop Date+ mm/yy	Discontinuation Code++
1st Biologic:			
2nd Biologic:			
3rd Biologic:			
4th Biologic:			

+For infusions, record stop date as date of last infusion.

++Discontinuation Code:
1. **Primary Failure** (Never achieved response)
2. **Secondary Failure** (Failure to maintain response after ≥ 3 months
3. **Adverse Event**
4. **Patient Choice** 5. **Funding**
6. **Other**

► **Are medications being prescribed/changed TODAY?:** ☐ No ☐ Yes.

If yes, answer the following questions:

► **Is the patient discontinuing any rheumatic drug(s) today?**
☐ No ☐ Yes ➡ Name:____________________ Discontinuation Code:_______
Name:____________________ Discontinuation Code:_______

► **Is the patient being prescribed NEW traditional DMARD(s) today?**
☐ No ☐ Yes ➡ DMARD Name(s):____________________ & _________________________

► **Is the patient changing the dose or route of administration of ongoing Biologic or DMARD today?**
☐ No ☐ Yes ➡ Name:________________ ☐ Change of Route ➡ From ____ to ____
Name:________________ ☐ Change of Dose ➡ From ____ to ____

► **Is the patient being prescribed a NEW biologic drug today?**
☐ No ☐ Yes ➡ Biologic Name:______________________________

► **If so, were Funding Support Forms Submitted:**
☐ No ☐ Yes ➡ Date forms submitted: ☐ **Today OR:** ____/____/_____(dd/mm/yyyy) ☐ Unknown

Signature: __________________ **Date:** _______________ (dd/mm/yyyy)

PLEASE FAX FORM TO:
1-888-757-6506