



Pre-referral workup checklist

The usual workup recommended before the referral is seen. Don't hold an urgent referral while waiting for results.

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What every referral should include

Your question. Diagnosis, treatment advice, a shared-care plan, or a second opinion. One clear question helps the triager most.

Onset and duration. The date symptoms began, and whether they are getting worse.

Red flags present or absent. Fever, weight loss, visual symptoms, weakness, breathlessness, kidney findings. Stating that they are absent helps too.

Treatments tried. NSAIDs and glucocorticoids with doses, dates and response. Steroids can mask synovitis and change test results.

Photos. With consent, photos of a transient rash, swelling or color change are often more useful than a description.

Working diagnosis and level of concern. Even a tentative one ("possible early RA"), and why you are worried.

What you found on examination. Which joints are swollen, not just painful; morning stiffness in minutes; rash, eye or nail findings; muscle strength.

Results with dates. Include titers, patterns and reference ranges. Attach reports rather than summarizing them where you can.

Context that changes the plan. Pregnancy or plans for it, infection history (TB, hepatitis), kidney or liver disease, cancer history, and access needs such as an interpreter or travel distance.

How to reach you. A direct number or secure message route, in case the triager has a quick question.

Inflammatory arthritis

Suspected RA, psoriatic arthritis, reactive or undifferentiated arthritis

Note: Don't hold the referral while waiting for results. Normal ESR, CRP, RF and anti-CCP do not exclude inflammatory arthritis.

History and examination

- ☐ Swollen joints drawn or listed (the strongest single clue), tender joints, and morning stiffness in minutes
- ☐ Symptom onset date and pattern: symmetric small joints, asymmetric large joints, DIP joints, dactylitis or enthesitis
- ☐ Psoriasis (personal or family), nail changes, inflammatory bowel disease, uveitis, recent GI or GU infection
- ☐ Function: grip, work, sleep. Smoking history.

Usual workup recommended before the referral is seen

- ☐ CBC with differential, metabolic panel with creatinine and liver tests
- ☐ ESR and CRP
- ☐ RF and anti-CCP
- ☐ Hepatitis B (HBsAg, anti-HBc, anti-HBs) and hepatitis C antibody, which are needed before most DMARDs
- ☐ Uric acid if gout is possible; urinalysis
- ☐ ANA only if there are features of connective tissue disease; HLA-B27 only with back pain, enthesitis or uveitis

Imaging

- ☐ X-rays of both hands and both feet (a baseline for erosions, even in early disease)
- ☐ X-ray of any other swollen joint

While the patient waits

- ☐ An NSAID is reasonable if safe for the patient.
- ☐ If possible, avoid glucocorticoids before the first visit. If they were needed, note the dose and dates.
- ☐ Ask the patient to photograph any swelling that comes and goes.

Axial spondyloarthritis

Chronic back pain that began before 45 with inflammatory features

Note: A normal pelvic X-ray does not rule out axSpA. HLA-B27 alone, without symptoms, is not a reason to refer.

History and examination

- ☐ Age at onset, duration (3 months or more), and inflammatory features: night pain, morning stiffness over 30 minutes, better with activity, alternating buttock pain
- ☐ Response to a full-dose NSAID (a good response supports axSpA)
- ☐ Uveitis, psoriasis, IBD symptoms, enthesitis (heel pain), dactylitis, family history

Usual workup recommended before the referral is seen

- ☐ CRP and ESR
- ☐ HLA-B27
- ☐ CBC and metabolic panel

Imaging

- ☐ AP pelvis radiograph as the first test. The 2026 ACR guideline prefers it over lumbar spine films or dedicated SI joint views.
- ☐ If X-rays are non-diagnostic, SI joint MRI without contrast is the next step. Follow your local pathway on who orders it.

While the patient waits

- ☐ A continuous NSAID trial (2–4 weeks at full dose) if safe
- ☐ Physical therapy referral, which the 2026 guideline strongly recommends
- ☐ Ask about eye pain or redness with light sensitivity, which needs same-day eye care

Gout and CPPD

Complex or refractory gout, recurrent pseudogout, diagnostic uncertainty

Note: A hot, swollen joint with fever needs same-day aspiration to exclude infection. Crystals and infection can coexist.

History

- ☐ Flare dates, joints involved and frequency over the past year
- ☐ Tophi, kidney stones, CKD, transplant, diuretics, alcohol and diet, family history
- ☐ Urate-lowering therapy: drug, highest dose reached, duration, adherence, flare prophylaxis, and why anything was stopped

Usual workup recommended before the referral is seen

- ☐ Serum urate, ideally 2 or more weeks after a flare (it can be normal during one)
- ☐ CBC, metabolic panel with eGFR and liver tests
- ☐ Joint fluid results (crystals, cell count, culture) if aspiration was done
- ☐ HLA-B*58:01 result if tested
- ☐ For CPPD starting before about 60: calcium, phosphate, magnesium, ferritin and transferrin saturation, alkaline phosphatase, TSH

Imaging

- ☐ X-rays of affected joints (erosions, tophi, chondrocalcinosis)
- ☐ Ultrasound or dual-energy CT can help in specialist hands; they are not needed before referral.

Connective tissue disease

Lupus, systemic sclerosis, myositis, Sjögren's disease, MCTD, antiphospholipid syndrome

Note: Kidney involvement, lung hemorrhage, rapidly worsening breathlessness, new severe hypertension in scleroderma, or swallowing or breathing weakness are emergencies. Call rather than refer.

Lupus (SLE)

- ☐ ANA with titer and pattern, anti-dsDNA, ENA panel (Sm, RNP, SSA/Ro, SSB/La)
- ☐ C3 and C4, CBC with differential, metabolic panel
- ☐ Urinalysis with microscopy and urine protein-to-creatinine ratio
- ☐ ESR and CRP; direct antiglobulin test if anemic
- ☐ Antiphospholipid antibodies if there is a history of clots or pregnancy loss
- ☐ Photos of rashes; pregnancy status or plans

Systemic sclerosis

- ☐ ANA with pattern, anti-centromere, anti-Scl-70, anti-RNA polymerase III
- ☐ CBC, metabolic panel, urinalysis, and blood pressure
- ☐ PFTs with DLCO and HRCT chest (ACR/CHEST 2023 screening), echocardiogram
- ☐ Note digital ulcers, skin thickening extent and speed of change, reflux or swallowing problems
- ☐ Nailfold capillaroscopy if available locally

Myositis

- ☐ CK, aldolase, AST/ALT, LDH, TSH
- ☐ CBC, metabolic panel, ESR/CRP, ANA, and a myositis-specific and myositis-associated antibody panel
- ☐ Troponin and ECG if there are any cardiac symptoms
- ☐ PFTs and HRCT if there is cough or breathlessness
- ☐ Statin history (dates, doses), swallowing and voice symptoms
- ☐ Age-appropriate cancer screening status

Sjögren's disease

- ☐ ANA, SSA/Ro, SSB/La, RF
- ☐ CBC, metabolic panel, urinalysis, IgG or serum protein electrophoresis, C3/C4
- ☐ Cryoglobulins if there is purpura or neuropathy
- ☐ List of drying medicines (anticholinergics, antihistamines, antidepressants)
- ☐ Dental and eye findings, gland swelling (location and duration)

Mixed connective tissue disease

- ☐ ANA and anti-U1 RNP
- ☐ CK, CBC, metabolic panel, urinalysis
- ☐ PFTs with DLCO, HRCT chest, echocardiogram

Antiphospholipid syndrome

- ☐ Lupus anticoagulant, anticardiolipin IgG/IgM, anti- β 2-glycoprotein I IgG/IgM
- ☐ Repeat positive tests at least 12 weeks apart
- ☐ Which anticoagulant the patient was on at the time of testing (it affects lupus anticoagulant results)
- ☐ Thrombosis history (sites, dates, provoking factors) and full pregnancy history
- ☐ CBC including platelets

General or undifferentiated

- ☐ ANA titer and pattern, ENA panel, anti-dsDNA, C3/C4
- ☐ CBC with differential, metabolic panel, urinalysis, ESR/CRP, TSH
- ☐ A symptom diary and photos of anything that comes and goes

Vasculitis and systemic inflammatory disease

GCA and PMR, Takayasu, ANCA vasculitis, cryoglobulinemia, Behçet's, PAN, adult autoinflammatory disease

Note: Ischemic symptoms, organ involvement or suspected MAS need a same-day call.

GCA and PMR

- ☐ Suspected GCA: call the same day and start glucocorticoids; don't wait for the workup
- ☐ ESR, CRP, CBC, metabolic panel with glucose
- ☐ Headache, jaw claudication, scalp tenderness, visual symptoms, limb claudication
- ☐ For PMR: CK, TSH, RF/anti-CCP and serum protein electrophoresis to look for mimics
- ☐ Glucocorticoid start date and dose, if already started

Takayasu arteritis

- ☐ Blood pressure in both arms, pulses, bruits
- ☐ ESR, CRP, CBC, metabolic panel
- ☐ CTA or MRA of the aorta and branches if available

ANCA-associated vasculitis

- ☐ PR3- and MPO-ANCA by antigen-specific immunoassay
- ☐ Urinalysis with microscopy, urine protein-to-creatinine ratio, creatinine
- ☐ CBC, CRP, chest imaging (X-ray or CT)
- ☐ ENT history (crusting, epistaxis, hearing), neurologic findings, eye symptoms

Cryoglobulinemic vasculitis

- ☐ Cryoglobulins (sample kept warm until the lab separates it), RF, C3/C4 (a low C4 is typical)
- ☐ Hepatitis C, hepatitis B, HIV, serum protein electrophoresis
- ☐ Urinalysis and creatinine

Behçet's syndrome

- ☐ Ulcer history: frequency, sites, photos
- ☐ Eye symptoms (needs ophthalmology), skin lesions, thrombosis history
- ☐ CBC, CRP, urinalysis. There is no diagnostic blood test, and HLA-B51 testing is not needed for diagnosis.

Polyarteritis nodosa

- ☐ Hepatitis B and C serology, ANCA (to exclude ANCA vasculitis)
- ☐ Urinalysis, creatinine, blood pressure
- ☐ Skin or nerve findings that could be biopsied; any angiography
- ☐ In younger patients, especially with stroke: consider DADA2 testing

Adult autoinflammatory disease (Still's, VEXAS, FMF)

- ☐ A fever diary and photos of any rash
- ☐ CBC with differential (note MCV and platelet trend), ferritin, CRP/ESR, liver tests, LDH
- ☐ Family history and ancestry (relevant for FMF)
- ☐ Infection and malignancy workup done so far

When to call instead of referring

- ☐ Suspected GCA, especially with any visual symptom
- ☐ Pulmonary-renal features: hemoptysis, rising creatinine, active urine sediment
- ☐ Mononeuritis multiplex, mesenteric ischemia, or a threatened limb or digit
- ☐ Persistent fever with cytopenias and a very high ferritin (possible MAS)

Pediatric rheumatology

JIA, fever syndromes, childhood lupus and dermatomyositis, vasculitis, and other conditions

Note: A child with fever and an acutely painful joint or bone, or refusal to bear weight, needs same-day assessment for infection. Night pain, cytopenias or a high LDH should prompt urgent evaluation for malignancy.

Joint swelling or limp (JIA)

- ☐ Which joints, how long (6 weeks or more suggests JIA), morning stiffness, limp, night pain
- ☐ CBC with differential, ESR, CRP, metabolic panel; LDH and a blood film if malignancy is possible
- ☐ ANA (for uveitis risk), RF and anti-CCP if polyarticular, HLA-B27 if enthesitis or back pain
- ☐ X-ray if trauma, infection or malignancy is a concern
- ☐ Arrange an ophthalmology screening exam now, and send the growth chart

Fever syndromes (sJIA, MAS, Kawasaki, MIS-C, periodic fever)

- ☐ A fever chart (pattern and duration) and rash photos
- ☐ CBC with differential, CRP, ESR, ferritin, liver tests, urinalysis, blood cultures
- ☐ If MAS is possible: fibrinogen, triglycerides, LDH, coagulation studies
- ☐ Echocardiogram for Kawasaki disease or MIS-C (usually arranged on admission)
- ☐ For periodic fevers: episode diary, labs during and between episodes, family history

Childhood lupus, dermatomyositis, scleroderma, Sjögren's

- ☐ The same antibody panels as for adults (see connective tissue disease above)
- ☐ Blood pressure, urinalysis with microscopy and urine protein-to-creatinine ratio
- ☐ CK, aldolase, AST, LDH for weakness; swallowing and voice symptoms
- ☐ Growth chart and pubertal stage

IgA vasculitis (HSP)

- ☐ Urinalysis, urine protein-to-creatinine ratio, creatinine, blood pressure
- ☐ Abdominal symptoms (intussusception risk)
- ☐ A plan for urine and BP checks for at least 6–12 months

Other pediatric referrals

- ☐ Neonatal lupus: maternal antibody results, infant ECG, CBC, liver tests
- ☐ Morphea: photos with a ruler, location (face or limb), any limb-length difference
- ☐ CNO: MRI and any biopsy results
- ☐ Acute rheumatic fever: ASO, anti-DNase B, ECG, echocardiogram

Other common referrals

Osteoporosis, osteoarthritis, widespread pain, soft-tissue problems, hypermobility

Note: Many of these patients are well served in primary care or MSK services first. Some rheumatology practices see them routinely; check your local pathway or use an e-consult.

Osteoporosis

- ☐ DXA results (with dates and sites), FRAX score, and fracture history including vertebral fractures
- ☐ Current and past treatment with dates (bisphosphonate, denosumab with the date of the last injection, anabolic agents)
- ☐ Calcium, 25-OH vitamin D, creatinine/eGFR, alkaline phosphatase, PTH and TSH if checked
- ☐ Glucocorticoid exposure (dose and duration)

Osteoarthritis with an atypical feature

- ☐ Why OA seems atypical: young onset, MCP or wrist involvement, rapid progression, or swelling
- ☐ X-rays of the affected joints
- ☐ Ferritin and transferrin saturation if hemochromatosis is possible; ESR/CRP

Widespread pain or fatigue

- ☐ CBC, metabolic panel, ESR/CRP, TSH; CK if weak or on a statin
- ☐ Treatments tried, sleep, mood and function
- ☐ The specific question (for example, "Is there inflammatory disease?"). Broad autoantibody panels rarely help without specific features.

Soft-tissue problems and hypermobility

- ☐ Usually best served by an MSK pathway (physical therapy, sports medicine, orthopedics) unless inflammatory features are present
- ☐ For hypermobility: dislocations, skin features, family history and vascular history (a genetics referral may fit better)

Lab-triggered referrals

When a result arrives without a clear clinical picture.

RESULT	USUALLY REFER WHEN	USUALLY NO REFERRAL NEEDED WHEN	WHAT TO SEND
Positive ANA	Titer 1:160 or higher with compatible symptoms, any positive disease-specific antibody, or unexplained cytopenias, proteinuria or hematuria	Low titer (1:40–1:80) with no symptoms and normal CBC, metabolic panel and urinalysis	Titer and pattern, why it was ordered, CBC, metabolic panel, urinalysis; ENA and anti-dsDNA if titer is 1:160 or higher
Anti-dsDNA, anti-Sm, anti-RNP, Scl-70, centromere	Usually refer, since these are disease-specific. Add urgency if kidney, blood or lung findings are present.	A low-level anti-dsDNA by a non-specific assay with a negative ANA may be a false positive. Ask the lab or an e-consult.	ANA, the full ENA panel, C3/C4, CBC, urinalysis with protein-to-creatinine ratio
Anti-CCP or RF	With objective joint swelling: urgent. High-titer anti-CCP with joint pain and no swelling: routine assessment.	Low-titer RF alone, especially in older adults or with chronic infection or liver disease	Titers, joint exam findings, ESR/CRP, hand and foot X-rays
Raised ESR or CRP	With features of PMR, GCA, inflammatory arthritis or vasculitis	A mild isolated rise with no symptoms. Look first for infection, malignancy, kidney disease, obesity, anemia or age-related change.	Trend over time, symptoms, CBC, metabolic panel, SPEP if ESR is high with a normal CRP
Positive ANCA	PR3- or MPO-ANCA positive with any compatible feature: urgent, or emergent with kidney or lung involvement	Immunofluorescence-only (atypical p-ANCA) positivity without features, which is common in IBD, infection and with some drugs	PR3/MPO immunoassay results, urinalysis with microscopy, creatinine, chest imaging
Raised CK	With proximal weakness, dysphagia, rash or a persistently raised CK after stopping a statin	A modest rise (under about 3–5 times normal) without weakness after exercise or injury, or in people of African ancestry with higher normal ranges. Repeat after a week without exercise.	CK trend, TSH, statin history, strength exam, AST/ALT, LDH
High uric acid	With complex or refractory gout (see triage)	Asymptomatic hyperuricemia. The ACR conditionally recommends against urate-lowering therapy here.	Urate trend, eGFR, flare history if any
HLA-B27 positive	With inflammatory back pain, enthesitis, uveitis or peripheral arthritis	Without symptoms. It is present in roughly 6% of the US population, and most carriers never develop spondyloarthritis.	Back pain features, CRP, AP pelvis X-ray
Low C3 or C4	With features of lupus, cryoglobulinemia or vasculitis, or an abnormal urinalysis	An isolated, mildly low C4 with no symptoms (inherited partial deficiency is common)	ANA, anti-dsDNA, cryoglobulins, urinalysis, creatinine
Antiphospholipid antibodies	Persistently positive (12 weeks or more apart) with thrombosis or pregnancy morbidity, or triple positivity	A single low-titer positive without events. Repeat in 12 weeks or more.	All three tests with dates, anticoagulant at time of testing, event history
Very high ferritin	With fever, rash and arthritis (Still's) or with cytopenias (possible MAS): urgent or emergent	A modest rise with iron overload, liver disease, alcohol or inflammation from another cause	Ferritin trend, CBC, liver tests, fibrinogen, triglycerides, CRP

RESULT	USUALLY REFER WHEN	USUALLY NO REFERRAL NEEDED WHEN	WHAT TO SEND
Anti-SSA/Ro in pregnancy	Yes. Coordinate rheumatology and maternal-fetal medicine for fetal heart monitoring and hydroxychloroquine.	—	Antibody results, gestation, any prior affected pregnancy

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