**Axial Spondyloarthritis (axSpA) Referral Proforma, East & North Hertfordshire NHS Trust**

Patient name:

Hospital number:

NHS Number:

DOB:

Patient telephone number (s):

Referring GP and surgery:

**Please attach an accompanying letter with past medical history**

**Please refer to rheumatology axSpA clinic if:**

**Lower back pain before the age of 45 years that has lasted for more than 3 months**.

**AND** if 4 or more of the following criteria is met:

* low back pain that started before the age of 35 years
* waking during the second half of the night because of symptoms
* buttock pain
* improvement with movement
* improvement within 48 hours of taking non-steroidal anti-inflammatory drugs (NSAIDs)
* a first-degree relative with spondyloarthritis
* current or past inflammatory arthritis
* current or past enthesitis
* current or past psoriasis

**If exactly 3 of the additional criteria are present, perform an HLA‑B27 test. If the test is positive, refer the person to a rheumatologist for a spondyloarthritis assessment.**

Suggested investigations to request: CRP, ESR, FBC, LFT, U&E.

Signed…………………………………… Date…………………………………