Tracking Number: ###### EIA-3 [A]

EIA Detection Tool Study

EIA-3 Detection Tool

To be completed by patient:

Enter **TODAY'S DATE**: _____/_____/____
Day / Month / Year

Enter your **MONTH** and **YEAR** of birth: _____/_____
Month / Year

What is your **GENDER**? Male _____ Female _____

Please circle **Yes** or **No** for each question

1	Do you have pain in your joints?	**Yes**	**No**
2	Do you have pain in your wrists and hands?	**Yes**	**No**
3	Are your hands or wrists swollen?	**Yes**	**No**
4	Do you have trouble making a fist?	**Yes**	**No**
5	Are your joints stiff in the morning?	**Yes**	**No**
6	From the time you wake in the morning, does it take more than 60 minutes for your joints to move more freely?	**Yes**	**No**
7	Are the same joints involved on both sides of your body?	**Yes**	**No**
8	Have important activities in your life been affected because of bone or joint problems, such as having difficulty with personal care or having to make a change regarding leisure or work activities?	**Yes**	**No**
9	Have you ever been told that you have rheumatoid arthritis?	**Yes**	**No**
10	Does anyone in your family have rheumatoid arthritis?	**Yes**	**No**
11	Have you been diagnosed with a rash called psoriasis?	**Yes**	**No**

FOR OFFICE USE ONLY:

Scoring: Enter the total number of **YES** answers: _____ / 11

Primary Care Provider: Date: _____ ICD-10 code _____ Diagnosis: _____

Name of Rheumatologist Referred to: _____

If Patient Not Referred to rheumatology, provide reason: _____

FAX completed Detection Tool to the Study Centre at **416.480.6949** c/o J. Scarf

