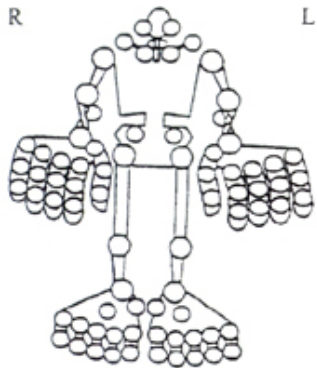


SECTION 2 – DIAGNOSIS: PRESENTATION AND INVESTIGATIONS (cont'd)

2.6 Joints affected with arthritis (please mark all affected joints on the diagram):



2.7 Clinical signs and symptoms:	No	Yes	Unknown		
2.7.1 Fever for at least 2 weeks If yes, specify if spiking daily	___	___	___		
2.7.2 Systemic JIA rash (erythematous macular or papular, evanescent, salmon-pink color)	___	___	___		
2.7.3 Hepatomegaly	___	___	___		
2.7.4 Splenomegaly	___	___	___		
2.7.5 Pericarditis	___	___	___		
2.7.6 Pleuritis	___	___	___		
2.7.7 Acute uveitis (painful or red eye)	___	___	___		
2.7.8 Chronic asymptomatic uveitis	___	___	___		
2.7.9 Patient has psoriasis	___	___	___		
2.8 Investigations:	No	Yes	Positive	Negative	Unknown
2.8.1 HLA B-27	___	___	___	___	___
2.8.2 Rheumatoid factor	___	___	___	___	___
2.8.3 Antinuclear antibody	___	___	___	___	___

SECTION 3 – MANAGEMENT

3.1 Medication that you prescribed:

- 3.1.1 Analgesics (such as acetaminophen, etc.): No ___ Yes ___
 If yes, specify name of medication _____ Date started: ___/___/___
DD MM YYYY
- 3.1.2 Anti-inflammatory (such as ibuprofen, naproxen, etc.): No ___ Yes ___
 If yes, specify name of medication _____ Date started: ___/___/___
DD MM YYYY
- 3.1.3 Steroids (such as prednisone): No ___ Yes ___
 If yes, specify name of medication _____ Date started: ___/___/___
DD MM YYYY
 If yes, specify method of administration: po ___ IV ___
- 3.1.4 Disease modifying agents (such as methotrexate, etc.): No ___ Yes ___
 If yes, specify name of medication _____ Date started: ___/___/___
DD MM YYYY
- 3.1.5 Other medications, please specify: _____

SECTION 3 – MANAGEMENT (cont'd)

3.2 Referral to:	No	Yes	Date of referral
3.2.1 Paediatric rheumatologist	___	___	___ / ___ / ___ DD MM YYYY
3.2.2 Adult rheumatologist	___	___	___ / ___ / ___ DD MM YYYY
3.2.3 Orthopedic surgeon	___	___	___ / ___ / ___ DD MM YYYY
3.2.4 Physiotherapist	___	___	___ / ___ / ___ DD MM YYYY
3.2.5 Other referrals: _____	___	___	___ / ___ / ___ DD MM YYYY

3.3 Final diagnosis:

3.3.1 Has the diagnosis changed since the initial JIA report? No ___ Yes ___

If yes, please specify: _____

If no, is there a JIA subtype assigned (refer to Appendix in protocol)?

No ___ Yes ___, subtype _____

3.3.2 Who assigned the subtype diagnosis? ER doctor ___ paediatrician ___ paediatric rheumatologist ___
adult rheumatologist ___ Other (please specify): _____

SECTION 4 – REPORTING PHYSICIAN

Paediatrician ___ Paediatric subspecialist ___ Other (please specify): _____

First name _____ Surname _____

Address _____

City _____ Province _____ Postal code _____

Telephone number _____ Fax number _____

E-mail _____ Date completed _____

Thank you for completing this form.