Physician Form

PLEASE FAX THIS FORM WHEN COMPLETED TO: DR. COLLEEN CORRELL, 612-626-1667

A. GENERAL PATIENT INFORMATION (Complete for all potentially eligible patients)

ID Number:	**Type of Juvenile Arthritis**
Sex: ☐female ☐male	☐ Systemic ☐ Oligoarticular, Persistent
Current Age: ____	☐ Polyarticular RF-negative ☐ Oligoarticular, Extended
Diagnosis Date: ___/___/_____	☐ Polyarticular RF-positive ☐ Psoriatic
	☐ Enthesitis-related ☐ Undifferentiated

B. PHYSICIAN PERMISSION TO BE CONTACTED (Complete for all potentially eligible patients. If yes, complete C below. If no, fax this form to study staff at 612-626-1667)

Yes or **No** (circle one): The parent/guardian of the this patient has indicated interest in learning more about *Juvenile Arthritis in Minnesota, JaMINN* conducted by Colleen Correll, MD, MPH at the University of Minnesota. Staff of the study *JaMINN* may contact this family in order to request informed consent to participate in this study.

SIGNATURE: _____ **Date:** _____
Physician Signature (or designee)

Please make a note of anything that the study staff should know when they contact this patient:

_____
_____
_____
_____

C. PATIENT INFORMATION (Complete for all patients with yes to B above.)

Patient First Name: _____ Birth Date: ____/____/_____

Patient Last Name: _____ Phone: (_____) _____-_____

Parent/Guardian First Name:_____ Alt phone: (_____) _____-_____

Parent/Guardian Last Name:_____

Relationship to patient:_____

Address: _____

City: _____ State: _____ Zip Code: _____

***information may also be completed at JaMINN.umn.edu**