



PATIENT REFERRAL FORM

FAX COMPLETED FORM & RECORDS TO: (866) 538- 3485

Company Information:

Facility: _____

Referring Physician: _____ Date: _____

Office Contact: _____ Phone: _____ Fax: _____

Patient Information:

Patient Name: _____ Email: _____

DOB: _____ Sex: Female Male Prefer not to say

Phone: (Primary) _____ (Secondary) _____

Address: _____

City: _____ State: _____ Zipcode: _____

Pharmacy: _____ City: _____ Phone: _____

Insurance Information:

Primary Insurance: _____

Subscriber Name: _____ Subscriber DOB: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Subscriber Name: _____ Subscriber DOB: _____

Policy Number: _____ Group Number: _____

REASON FOR REFERRAL:

___Rheumatoid /Inflammatory Arthritis ___Psoriatic Arthritis /Psoriasis ___SLE /Lupus ___Sjogren’s ___Other CTD

___Inflammatory back pain /Ankylosing Spondylitis /SpA ___PMR/GCA ___Vasculitis ___Abnormal Labs ___Other

Comments:

Please attach medical records with this request: Demographics Physician Notes Imaging Results (prior 2 yrs.) Our office will contact the patient to schedule the appointment and fax back this form to your office so that the referring doctor is aware of the appointment date and time. Our office will make 3 attempts to reach the patient and will hold the referral for up to 3 months. The patient will receive a reminder text at least 2 days prior to their appt.

The Patient Listed above has been scheduled with

Dr. _____

Date: _____ Appt Time: _____ Arrival Time: _____