Arthritis & Rheumatology Center, PC
Phone : (770) 284 3150 Fax : (770) 284 3170
www.arcenterpc.com
Roswell / Alpharetta – Cumming – Johns Creek / Suwanee

RHEUMATOLOGY CONSULTATION REFERRAL FORM

***** If your patient has not heard from us within 2 days of faxing this referral form, Please have the patient call our referral coordinator at 770-284-3150*****

PATIENT INFORMATION

PATIENT'S NAME: ______________________________ DOB: ____________________

ADDRESS: ____

MAIN PHONE #: ____________________ 2ND PHONE #: ______________________

INSURANCE COMPANY: __________________ INSURANCE ID#: __________________

REFERRING PHYSICIAN INFORMATION

PHYSICIAN: ____

ADDRESS: ____

NPI#: ____

PHONE#: _________________________ FAX#: ____________________________

CONTACT PERSON: ____________________ CONTACT PHONE/EXT: ____________________

[ ] _____pages of records are attached (insurance info, labs, x-ray, office visit notes)
Please include any lab or x-ray reports so that we don't duplicate testing

Reason for Consultation

[ ] Joint pain	[ ] Muscle Pain	[ ] Rheumatoid Arthritis
[ ] Arthritis	[ ] Osteoarthritist	[ ] Gout/Pseudogout
[ ] Positive ANA	[ ] Abnormal labs	[ ] Positive CCP testing*
[ ] Lupus (SLE)	[ ] Osteoporosis	[ ] Raynaud's
[ ] Fibromyalgia	[ ] Vasculitis	[ ] Sjögren's (dry eye/mouth)

[ ] Other: ____

[ ] Diagnosis: ______________________________________

PLEASE SEND MEDICAL RECORDS & INSURANCE CARD. FAX THIS REFFERAL TO 770-284-3170

Thank you for your Referral