Chi Arthritis & Rheumatology Associates

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RHEUMATOLOGY REFERRAL FORM

Patient Name:_____ DOB:_____

Address:_____ City:_____ ZIP:_____

Home Phone #:_____ Work #:_____ Cell#:_____

Insurance(s):_____ Patient SS#: _____

Policy #: _____ Group #: _____

Guarantor if Other Than Patient: _____

Relationship to Patient: _____

Chief Complaint of Patient: _____

Onset Date of Symptoms: _____

Referring Physician Suspects? (Please circle all that apply.)

Rheumatoid Arthritis Lupus Myositis Scleroderma Osteoarthritis

Ankylosing Spondylitis Antiphospholipid Syndrome Vasculitis Bursitis Gout

Other: _____

_____

Referring Provider: _____

Telephone # of Provider: _____ Fax #: _____

Provider Signature: _____

Urgency of Visit:
Check one

1 Day _____

1 Week _____

2 Weeks _____

1 Month _____

Next Avail

Fax to us at (501) 500-5008 the last 3 Clinic Notes and all pertinent labs

Clinical Information: A rheumatology scheduling secretary will be contacting the patient directly to make the appointment based on the information given on this sheet.

Appointment Date: _____ ***Time:*** _____

Appointment Location:

3333 Springhill Drive, Suite 2040
North Little Rock, AR 72117

6 Shackleford Drive
Little Rock, AR 72211