



Great Lakes Center of Rheumatology West

Arthritis, Osteoporosis, and Autoimmune Diseases

Consult Request to the Great Lakes Center of Rheumatology West

Date: _____ Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

We will consult and treat for Rheumatology related medical issues only.

Requesting: First Available

Patient Name: _____ Sex: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Alt Phone: _____

Family Physician: _____

Medicaid Yes No- We are not accepting patients with Medicaid primary or secondary.

Workman's Comp Yes No- We are not accepting patients with Workman's Comp.

Pending auto related case Yes No- We are not accepting patients with auto cases pending.

Type of Insurance: Medicare BCBS PHP BCN AETNA Other: _____

APPOINTMENT REQUESTED Urgent Routine

Reason for consultation, symptoms, diagnosis: _____

Signature of requesting physician or office staff: _____

***** Please send recent office notes, labs, and x-rays *****

After the above patient is scheduled, we will complete the bottom portion and return by fax.

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Appointment Date: _____ Time: _____ Faxed by: _____ Date: _____

This information is confidential and is entrusted to the person whose name appears on this form. Unauthorized use of this information is a breach of confidentiality, and the Great Lakes Center of Rheumatology West will report all such violations to the appropriate authorities and will assist in the prosecution of all violators. If you receive this fax in error, please destroy this material and call us so we can correct the error.