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.

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

4333 W. St. Joe Highway, Lansing, MI 48917-4297 PHONE (517) 321-1525 FAX (517) 321-7059