Great Lakes Center of Rheumatology

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In order to treat your patient more efficiently, we would appreciate the following information to be sent with this referral before we schedule the appointment:

1. TREATMENT HISTORY (this includes progress notes)
2. X-RAY AND LAB REPORTS (if no current labs have been done, Dr. June would appreciate the patient to have the following drawn PRIOR to scheduling: CBC, CHEM PROFILE, ESR, ANA, ANCA panel, ENA, SPEP, RF, CPK, TSH)
3. MEDICATION LIST
4. COPIES OF ALL INSURANCE CARDS

FAX CONSULT FORM

(PLEASE FILL OUT COMPLETLEY)

NAME: _____ DOB:_____ MALE / FEMALE
ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
HOME PHONE:_____ WORK PHONE:_____ CELL:_____ OTHER:_____
IF PATIENT IS MINOR, NAME OF GAURDIAN:_____
INSURANCE: _____

BCN ONLY, Global Authorization Number: _____ Group NPI: _1548717580_

PLEASE NOTE: Medicaid or County Health Plan patients are accepted on a case-by-case basis. Information will be forwarded.

DIAGNOSIS/REASON FOR REFERRAL: _____

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN:_____ MD/DO NPI:_____
PHONE:_____ FAX:_____
PRIMARY CARE PHYSICIAN:_____
PHONE:_____ FAX:_____

DATE:_____

TIME: _____

PROVIDER:_____

APPOINTMENT VERIFICATION

We will attempt to call patient twice, if no return call is made we will return this referral to your office.

1st Attempt_____

2nd Attempt_____

THANK YOU FOR YOUR REFERRAL!