

Great Lakes Center of Rheumatology
Arthritis, Osteoporosis, and Autoimmune Diseases

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Phone: 517-272-9700 Fax: 517-272-9706 or 517-853-8238

New Patient Referral Form

Date: _____ Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

We will consult and treat for Rheumatology related issues ONLY

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

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Family Physician: _____

Insurance: ☐ Medicare ☐ BCBS ☐ PHP ☐ BCN ☐ AETNA ☐ Other: _____

***** Please send the last 2 recent office notes, labs, and imaging ****

If the correct information is not received, the referral will be **denied and sent back to the referring office** due to lack of information.

APPOINTMENT REQUESTED

☐ Urgent

☐ Routine

Reason for consultation, symptoms, diagnosis: _____

WE DO NOT ACCEPT UNITED HEALTHCARE, WORKMANS COMP

OR AUTOMOTIVE RELATED CASES

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