

Joint Endeavors Rheumatology Specialists Referral Form
Carolyn Gleason MD Lisa June MD
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FAX (877) 591-0879

If urgent appointment is needed, please call **502-890-3899** to speak with a scheduling representative.

Please fill out this form completely.

Patient Information:

Name: _____

DOB: _____

Address: _____

Telephone: _____

PLEASE INCLUDE THE FOLLOWING:

- **Recent office note**
- **Pertinent lab**
- **Xray results**
- **Copy of Insurance card(s).**

We do not accept HMOs, Medicaid, Passport, WellCare, CareSource

Referral to: (circle choice) Dr. Gleason Dr. June 1st Available

Reasons for Referral: _____

Referring Provider Name _____

NPI# _____

Address: _____

Phone: office _____ Fax: _____

Fax all documents to 877-591-0879. Missing information (including clinical documentation) may result in a processing delay.

A scheduling representative will work with your patient to coordinate the appointment. Your office will receive notification via fax once the appointment has been scheduled. To contact via telephone, please call 502-890-3899 to speak with a scheduling representative.