SPECIALIST CONSULTATION REQUEST FORM

for Patients With Suspected or Confirmed Rheumatoid Arthritis

Date of patient visit (mm/dd/yy) _____

REFERRAL FORM

To be completed by referring physician's office staff

Referring Physician and Other Office Point of Contact: _____

Phone: _____

Email: _____

Patient summary:

Patient Name: _____

Gender: _____ Date of Birth (mm /dd/yy): _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Patient Insurance Information: _____
(Send copy of front & back of medical and prescription cards with this form)

Patient's Preferred Language: _____

Does Patient Need a Translator?..... ○ Yes ○ No

History of Tuberculosis (TB) or Positive TB Test?..... ○ Yes ○ No
(Date of Test: _____) ○ Test not Performed

Reason for consultation: Suspected rheumatoid arthritis

- ○ Inflammatory Arthritis
- ○ Morning Stiffness for >60 minutes
- ○ Joint Pain
- ○ Swollen Joints: >1 small or ≥2 large

Scheduling time: ..... ○ Urgent ○ Within 1-2 weeks ○ Within 4 weeks

Currently available additional information (Check all that apply & send results to specialist):

- ○ Copy of office notes indicating reason for referral
- ○ X-ray films or reports
- ○ Medication list (please ask patient to bring medication list to appointment)
- ○ MRI/CT films & reports
- ○ Pertinent laboratory results
- ○ Vaccination history
- ○ Additional relevant medical history (eg, comorbid conditions, impact on work, etc):

Send to specialist :

- ○ Medication list
- ○ Completed referral form
- ○ Pertinent test results
- ○ Clinical notes
- ○ Copy of patient's insurance cards (medical and pharmacy benefits)
- ○ X-ray films
- ○ MRI/CT films

SPECIALIST CONSULTATION FORM

for Patients With Suspected or Confirmed Rheumatoid Arthritis

Date of patient visit
(mm/dd/yy)
_____

SPECIALIST CONSULTATION SUMMARY

To be completed by specialist office staff once patient has been seen or if patient did not make appointment

Consulting Specialist: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Email (optional): _____

Patient summary:

Patient Name: _____

Gender: _____ Date of Birth (mm/dd/yy): _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Patient status:

Diagnosis:

_____

Treatment Plan Recommendation(s):

Prescribed Medication(s):

Send this form back to referring physician:

- ○ We have scheduled your patient
  Appointment Date _____
  Appointment Time _____
- ○ Patient cannot be seen in time frame requested
- ○ We have contacted your patient
- ○ Patient did not make an appointment
- ○ Patient was a no-show