PHONE: 864-235-8396
FAX: 864-271-4092
WWW.PIEDMONTARTHRITIS.COM

RHEUMATOLOGY CONSULTATION REFERRAL FORM

***** If your patient has not heard from us within 2 days of faxing this referral form, Please have the patient call our referral coordinator at 527-2311*****

PATIENT INFORMATION

DATE OF BIRTH: ______________________________

FULL NAME: ______________________________

ADDRESS: ______________________________

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MAIN PHONE #: ______________________________

2ND PHONE #: ______________________________

PRIMARY INSURANCE: ______________________________

PRIMARY INSURANCE ID#: ______________________________

SECONDARY INSURANCE: ______________________________

SECONDARY INSURANCE ID#: ______________________________

SOCIAL SECURITY #: ______________________________

EMAIL: ______________________________

REFERRING INFORMATION

PHYSICIAN: ______________________________

ADDRESS: ______________________________

____

NPI#: ______________________________

PHONE#: ______________________________

FAX#: ______________________________

CONTACT PERSON: ______________________________

CONTACT PHONE/EXT: ______________________________

PLEASE CHECK ONE (REQUIRED):

- ❑ CONSULT/RECOMMENDATIONS ONLY
- ❑ EVALUATION, AND TREATMENT
- ❑ URGENT – SEE MEDICAL RECORDS

REASON FOR REFERRAL:

DX:

SCHEDULE WITH:

- ❑ **Any Doctor – First Available**
- ❑ **Dr. Jeffrey Lawson**
- ❑ **Dr. Josette Johnson**
- ❑ **Dr. Geneva Hill**
- ❑ **Dr. Holly Bastian**

PLEASE SEND MEDICAL RECORDS & INSURANCE CARDS

We cannot schedule your patient's appointment without THIS FORM (filled out completely), recent office notes, all labs or x-rays, and a copy of the patient's insurance card(s).

THANK YOU FOR YOUR REFERRAL!