



PHONE: 864-235-8396
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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: _____

MAIN PHONE #: _____

2ND PHONE #: _____

PRIMARY INSURANCE: _____

PRIMARY INSURANCE ID#: _____

SECONDARY INSURANCE: _____

SECONDARY INSURANCE ID#: _____

SOCIAL SECURITY #: _____

EMAIL: _____

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. Long Huynh-Duc

REFERRING INFORMATION

PHYSICIAN: _____

ADDRESS: _____

NPI#: _____

PHONE#: _____

FAX#: _____

CONTACT PERSON: _____

CONTACT PHONE/EXT: _____

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!!