Integrative Rheumatology

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REFERRAL FORM – Please Fax to 704-774-3045

Date: _____

Patient Information

Name (First, MI, Last): _____

DOB (mm/dd/yyyy): _____ Gender: ❑M ❑ F Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Information

Insurance Company: _____ ❑ Referral auth required

Subscriber ID#: _____ Group#: _____

Policy Holder's Name: _____ DOB (mm/dd/yyyy): _____

Authorization #: _____ Dates & # of Visits allowed: _____

Referral Information

Referring MD: _____ This is the patient's PCP ❑

Office Name & Address: _____

Coordinator: _____ Office Phone: _____ Fax: _____

Reason for Referral: _____

Urgency: ❑ EMERGENT (within 1-3 days) ❑ Urgent (within 1 week) ❑ Routine

***We cannot guarantee availability of appointments but will do our best to help accommodate the patient's needs.*

Included Documents:

- ❑ Demographic information
- ❑ Copy of insurance card
- ❑ Office Notes
- ❑ Lab results
- ❑ Imaging
- ❑ Other _____

Number of Pages *(including cover)* _____