



Integrative Rheumatology

10826 Mallard Creek Rd, Ste 100 | Charlotte, NC 28262
O: 704.774.3044 | F: 704.774.3045 | www.InRheum.org

Charles A. Withers, II, M.D. – Rheumatologist

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:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Demographic information | <input type="checkbox"/> Lab results |
| <input type="checkbox"/> Copy of insurance card | <input type="checkbox"/> Imaging |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Other _____ |

Number of Pages (including cover) _____

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