ARTHRITIS CLINIC & MEDICAL ASSOCIATES P.C

Rheumatology Referral Form

PLEASE NOTE: This form gives our physicians valuable information regarding your patient's history and symptoms. However, it is still necessary for you or your patient to call **(763) 463 9515** to schedule an appointment.

Patient Name: _____Date of Birth: _____

Patient Phone Number(s): home_____work/mobile_____

***Referring Physician*: _____**

***Office Address*: _____*City*: _____**

***Zip*: _____ *Phone:(____)_____ Fax: (____)_____**

[ ] _____pages of records are attached (insurance info, labs, x-ray, office visit notes)

Please include any lab or x-ray reports so that we don't duplicate testing

Scheduling time: [ ] Urgent (1-7 days) [ ] within 2 wks [ ] 2-4 wks

Reason for Consultation: _____

_____

Specific Questions to be answered by Consult: _____

_____

_____

Please note: We do not accept referrals for disability evaluations or worker's compensation evaluations.

Thank you for trusting us with the care of your patient. We will be happy to contact the patient and notify your office when we schedule this appointment.

PLEASE FAX THIS FORM TO (763) 390 4035

www.arthritisclinicmn.com

APPOINTMENT LINE: (763) 463 9515 or (763) 634 2273

**Please send any pertinent records/imaging to our office by fax: (763) 390 4035 , or by mail:*
Arthritis Clinic & Medical Associates • Attn: Medical Records • 536 Cedar Street • Monticello, MN 55362