

Referral Form Adult Rheumatology Clinic

Please fax all office notes, labs, and radiology reports pertinent to your referral with this form so that we may process your request.

PROVIDERS

Physicians

Daniel A. Albert, MD
(Section Chief)
Lin A. Brown, MD
(Fellowship Director)
Christopher M. Burns, MD
Douglas F. Marks, Jr., MD
Nicole Orzechowski, DO
William F.C. Rigby, MD
Robert L. Wortmann, MD
John H. Yost, DO

Mid-Level Provider

Debra C. Lloyd, APRN, MS

Patient Name: _____

DOB: _____ **SSN:** _____

Address: _____

Home Ph: _____ **Work Ph:** _____

Referring Physician: _____

Address: _____

Phone: _____ **Fax:** _____

Reason for Referral (include tentative diagnosis, laboratory results and radiology reports):

Length of Symptoms: _____

Is your patient taking any of the following medications? (please check all that apply)

Steroids Narcotics Antidepressants

Previous Rheumatology Consult (please check one) Yes No

If yes, provide notes and labs.

Urgency of Visit:

1 DAY:	1 WEEK:	2 WEEKS:	1 MONTH:
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Please note: We do not accept referrals for the following:

- Chronic Pain
- Chronic Lyme Disease
- Chronic Fatigue
- Worker's Comp/Disability
- Fibromyalgia: one-time consultation through a shared medical appointment.

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