Dartmouth Health

Dartmouth Hitchcock Clinics

Phone: (603) 695-8655
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Rheumatology (Adult& Pediatric)

Specialty (check one): ❑ Adult Rheumatology ❑ Pediatric Rheumatology

Clinical Information: Please note that a Rheumatology referral coordinator will be contacting the patient directly 3-5 days after receiving the below listed information to make the appointment based upon the information given on this sheet.

Specific question to be answered by consult: _____

_____

Tentative diagnosis: _____

_____

Length of time patient has had symptoms: _____

_____

Data previously obtained to evaluate symptoms: _____

_____

Test results:

RF:_____ ANA:_____ CRP:_____ SED Rate:_____ Other:_____

Before faxing this referral form, please check the following information which is included so that we may process your referral in a timely fashion.

❑ Pertinent office notes (necessary). ❑ Medication list(necessary). ❑ Additional pertinent testing information