Dartmouth Health

Dartmouth Hitchcock Medical Center
DEPARTMENT OF MEDICINE
RHEUMATOLOGY
Phone: 603-650-8622
Fax: 603-676-4080

Rheumatology Referral Form

Thank you for your referral. Please provide the information requested below to expedite the referral process and treatment plan. FAX the completed form AND copies of recent office visits, medication and allergy list, relevant lab/diagnostic tests, patient demographics, and a copy of patient insurance cards to fax# 603-676-4080. Missing information will result in delays in processing the referral.

Patient Name: _____ DOB:_____ Male Female

Address: _____ City:_____ State:_____ Zip:_____

Phone #:_____ Secondary Phone #: _____

PCP:_____

Insurance (include copy of card):_____

Group #:_____ Subscriber Name:_____ Subscriber DOB:_____

Referring Provider:_____ Office Name:_____

Office Address: _____ City:_____ State:_____ Zip:_____

Phone #:_____ Fax #:_____

Has patient previously seen a Rheumatologist? ☐ Yes ☐ No
Will the patient need an interpreter? ☐ Yes (Language:_____) ☐ No

Referring Provider: Please **CHOOSE ONE** of the following categories/reasons for the Rheumatology referral. Check mark it **and** provide additional information as requested. If previously seen by a Rheumatologist, please provide notes from that provider. If patient has a rash, please refer to Dermatology.

☐ **Inflammatory Arthritis (Rheumatoid Arthritis, Psoriatic Arthritis)**

- ☐ Exam shows swollen small joints (hands, feet, etc.)
- ☐ Exam shows swollen large joints (knees, shoulders, etc.)
  - ☐ X-ray of affected joint(s)

Nail pitting: Yes No

RF+:_____

CCP+_____

- ☐ Elevated CRP:_____ ☐
- ☐ Elevated ESR:_____

☐ **Lyme**

- ☐ # of antibiotic courses:_____ ☐
- ☐ Which antibiotic(s):_____ ☐
- ☐ How was it diagnosed:_____

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☐ **+ANA (please provide clinical symptoms or lab abnormalities)**

- ☐ Pleurisy
- ☐ Pericarditis
- ☐ Cytopenias
- ☐ +dsDNA
- ☐ AM stiffness >1 hour
- ☐ Proteinuria
- ☐ Tight Skin
- ☐ Joint Pain
- ☐ Kidney Disease (Nephrology referral & biopsy)
- ☐ Malar Rash
- ☐ Recurrent Fevers
- ☐ Swollen Joints
- ☐ Raynaud's
- ☐ Photosensitivity
- ☐ Sicca Symptoms
- ☐ ENA
- ☐ Rash (Derm referral & biopsy)

☐ **Ankylosing Spondylitis (Spondyloarthropathies)**

- ☐ Prominent nocturnal pain/awakening at night
- ☐ AM Stiffness >1 hour
- ☐ Elevated ESR or CRP:_____
- ☐ If positive & with back pain: SI and lumbar spine x-rays
- ☐ If negative & with back pain: MRI of SI & lumbar spine
- ☐ Responsive to NSAIDs
- ☐ HLA-B27+:_____

☐ **Giant Cell Arteritis/PMR**

- ☐ Onset of symptoms:_____
- ☐ Steroid started: When?_____
- Temporal artery biopsy done? Yes ☐ No ☐ ☐ Elevated ESR/CRP:_____
- ☐ Vision loss or changes (if yes, send to Ophthalmology or Emergency Room)

☐ **Systemic Vasculitis**

☐ Lungs ☐ Kidneys (Nephrology referral, biopsy ☐ Nervous System (Neurology referral)
☐ Skin ☐ Other:_____

Onset:_____
Abnormal labs:_____
Any other concerns:_____

☐ ANA ☐ ANCA ☐ Urinalysis

☐ **Crystalline Arthritis** (Gout, Pseudogout)

- ☐ Joints involved:_____
- ☐ X-ray of affected joints
- ☐ Therapies already tried:_____

Crystals previously documented: Yes ☐ No ☐

☐ **Osteoarthritis**

Please list *specific* goals: confirm dx, joint injections, other:_____

☐ **Sjogren's Syndrome**

- ☐ ANA+:_____
- ☐ La+:_____
- ☐ Lip biopsy
- ☐ Ro+:_____
- ☐ Eye evaluation
- ☐ Medications:_____

☐ **Other**: _____

_____