RHEUMATOLOGY & OSTEOPOROSIS CENTER of Memphis

PH# 901-309-5000 FAX# 901-309-5008

DATE: _____

(fields marked ** are required)

NEW PATIENT REFERRAL FORM

Records required for Referral. . .

- Recent office notes (required)
- Lab Reports (if applicable)
- Imaging / Diagnostic Reports (if applicable)
- Copy of Insurance Card (required)
- Demographics Page (required)

FAX # 901-309-5008

****Diagnosis / Reason for Referral:** _____

****Has this patient been seen by a Rheumatologist previously? YES or NO**

If YES, please list name of doctor and year last seen**:** _____

Patient Information

****NAME:** _____ ****Date of Birth:** _____

****Address:** _____

****City/State:** _____ ****Zip:** _____ ****SSN:** _____

****Primary Phone:** _____ **Secondary Phone:** _____

****Does this patient have any communication, language or special needs?** _____

Referring Physician Information

****Name:** _____ **NPI:** _____

****Address:** _____

****Office Contact:** _____ **Email:** _____

****Direct Phone:** _____ ****Office Phone:** _____ ****Office Fax:** _____

Insurance Information (Please send a copy of front & back of insurance card)

****Primary Insurance:** _____ ****Insured's Name:** _____

****Policy/Group #** _____ ****Phone #** _____

****Policy Holder Name:** _____ ****Policy Holder DOB:** _____

Secondary Insurance: _____

Thank you for the referral and entrusting Rheumatology & Osteoporosis Center to care for your patient.