



**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)

**NEW PATIENT FAX REFERRAL FORM**

(fields marked \*\* are required)

**\*\*Diagnosis / Reason for referral:** \_\_\_\_\_

**\*\*Has the patient been seen by a Rheumatologist previously?** (circle)      YES    NO

If YES, please list Name of Doctor and year last seen: \_\_\_\_\_

**\*\*Requested Provider:** \_\_\_\_ Dr. David Boatright \_\_\_\_ Dr. Hugh Holt \_\_\_\_ Dr. Matthew Lyons \_\_\_\_ Dr. Yamini Menon \_\_\_\_ 1ST Available

**Patient Information**

**\*\*Patient Name:** \_\_\_\_\_ **\*\*DOB:** \_\_\_\_\_      M \_\_\_\_ F \_\_\_\_

**\*\*Address:** \_\_\_\_\_

**\*\*City/State:** \_\_\_\_\_ **\*\*Zip:** \_\_\_\_\_ **\*\*SSN:** \_\_\_\_\_

**\*\*Primary Phone:** \_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_ **email:** \_\_\_\_\_

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

**Patient Insurance** (please send a copy of the front and back of the patient insurance)

**\*\*Primary Insurance:** \_\_\_\_\_ **\*\*ID / Group:** \_\_\_\_\_ **Subscriber:** \_\_\_\_\_

**Second Insurance:** \_\_\_\_\_ **ID:** \_\_\_\_\_ **Subscriber:** \_\_\_\_\_

**Referring Provider Information:**

**\*\*Name:** \_\_\_\_\_ **NPI:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**\*\*Office Contact:** \_\_\_\_\_ **email:** \_\_\_\_\_

**\*\*Direct Phone:** \_\_\_\_\_ **\*\*Office Phone:** \_\_\_\_\_ **\*\*Office Fax:** \_\_\_\_\_

**Please fax this form, along with the records requested above, to 901-309-5008**

**Please contact the office at 901-309-5000 with any questions.**