WVUMedicine

UNITED HOSPITAL CENTER

Rheumatology
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REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (681) 342-3491

Referring Provider: _____ **Referring Office Name:** _____

Referring Provider Phone #: _____ **Office FAX #:** _____

Primary Care Provider: _____ **Today's Date:** _____

Person Completing Form: _____ **Patient's SSN:** _____

Patient's Name (F,MI,L): _____

Patient's Address: _____

Patient's Date of Birth: _____ **Patient's Phone #:** _____

Patient's Insurance/Auth #'s: _____

Has the patient previously been seen by a Rheumatologist? ____ **If so, please list the physician:** _____

Reason for Referral (please be specific): _____

_____

_____

_____

Please Note:

❒ Please include most recent progress notes, labs, x-rays, MRI, CT reports, and procedure reports.

❒ Please include any additional information pertinent to this referral.

❒ We will notify the patient by mail or phone of appointment time and date.

Thank you for your referral. Please do not hesitate to call us with any questions or concerns.

Office Use Only
Provider:
EPIC MRN:
Appointment Date:
Appointment Time: