



Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

AppRheumatology
 2146 Blowing Rock Rd | Boone, NC 28607
 Phone| 828.386.2300 Fax| 828.386.2301

**Referral Form
Form #11680**

Date: _____ Referring Office Contact Person: _____

Referring Physician: _____

Telephone #: _____ Fax #: _____

Reason for Referral: _____

PATIENT INFORMATION

Patient Full Name: _____

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

Home phone #: _____ Daytime phone #: _____

Last 4 Digits of SSN: _____ DOB: _____ Gender Male Female

INSURANCE INFORMATION

Insurance Name/Type: _____

Group#: _____ ID#: _____

MEDICAL HISTORY

Has the patient had prior lab work? Yes No

Has the patient seen a Rheumatologist? Yes No

Comments: _____

Please fax this completed form to the fax number listed above along with:

- Copy of patient's insurance card(s) front and back.
- Copies of 2-3 most recent office notes.
- Copies of any imaging reports (X-ray, MRI, CT) and lab reports that are related to the patient's symptoms.

APPOINTMENT INFORMATION (FOR ARR USE ONLY)

Patient aware of appointment Unable to contact patient

Appointment date: _____ Time: _____ am / pm

Physician: _____ Location: _____