WILMINGTON HEALTH RHEUMATOLOGY PATIENT REFERRAL FORM

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Please include all pertinent clinical notes, labs results, radiology reports, and demographics including insurance, unless patient records are in Wilmington Health electronic records. Appointment will not be made without the above mentioned information.

Patient Name: _____ DOB: _____ SSN#:_____

Address: _____ Email Address: _____

Home Phone: _____Work/Cell Phone: _____

INSURANCE: Primary: _____ Secondary: _____

ID#:_____ ID#:_____

Group#:_____ Group#:_____

Tricare Prime – We require authorization before scheduling.

Carolina Access- NPI#: _____ & Duration: _____

Urgent referral indicates that this patient is acutely ill and unstable requiring immediate attention of a rheumatologist. We encourage physicians to call and speak to one of our staff to expedite the evaluation of a sick patient.

URGENT REFERRAL REQUEST ☐ PROVIDER REQUESTED: _____

(OR) FIRST AVAILABLE ☐

Referring MD/PA-C/FNP: _____

Contact Person: _____ Phone: _____ Fax: _____

Type of referral: (please check box below)

Rheumatoid Arthritis ☐ Osteoarthritis ☐ Osteoporosis ☐ Abnormal Labs ☐ Vasculitis ☐ Gout

☐ Other: _____

Staff Only

Patient is scheduled with (Provider) _____on (Date & Time)_____

Unfortunately providers are unable to accept patient at this time. ☐