



NEW PATIENT REFERRAL/CONSULTATION

Please complete entire form and attach copies of prior pertinent clinic notes, labs, imaging results and discharge summaries. We cannot schedule an appointment until this information is received.

PATIENT INFORMATION

UNC MR# (if known):

Form with fields: LAST NAME, FIRST NAME, MIDDLE NAME, PRIMARY PHONE, ALTERNATE PHONE, SEX, BIRTH DATE, RACE, STREET ADDRESS, CITY, STATE, ZIP

CHECK SYMPTOM(S) / PHYSICAL EXAM FINDINGS

Grid of checkboxes for symptoms: Joint Swelling, Skin Rashes, Skin Ulcers, Muscle Weakness, Positive Serology, etc.

All new patients are seen for an initial consultation at the request of referring physicians. UNC Hospitals Rheumatology Specialty provider will determine the need for transfer of care to UNC Hospitals Rheumatology Specialty Clinic at the time of initial consult.

SPECIFIC QUESTION(S) TO BE ADDRESSED:

Is this for a second opinion? Yes No

PRIMARY CARE PHYSICIAN INFORMATION

Form with fields: PHYSICIANS NAME, PRACTICE NAME, STREET ADDRESS, CITY, STATE, ZIP, PHONE, FAX, EMAIL ADDRESS

REFERRING PHYSICIAN INFORMATION

Form with fields: PHYSICIANS NAME, PRACTICE NAME, STREET ADDRESS, CITY, STATE, ZIP, PHONE, FAX, EMAIL ADDRESS

INSURANCE POLICY HOLDER INFORMATION (PLEASE ALSO ENCLOSE COPY OF INSURANCE CARD)

Form with fields: POLICY HOLDER'S RELATIONSHIP TO PATIENT, LAST NAME, FIRST NAME, SEX, BIRTH DATE, PRIMARY PHONE, PRIMARY INSURANCE CARRIER, POLICY #, GROUP #, EFFECTIVE DATE, SECONDARY INSURANCE CARRIER, POLICY #, GROUP #, EFFECTIVE DATE

-Additional information on reverse side-

SCREENING STATUSES AND IMMUNIZATIONS

Please complete as much information as is available.

Infectious Disease Screenings	Date of last Immunizations:	Date of last cancer screening?
Hepatitis C Serology: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> NA	Pevnar: _____	Pap smear: _____
Hepatitis B Serology: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> NA	Pneumovax: _____	Colonoscopy: _____
HIV: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> NA	Influenza: _____	Mammogram: _____
Quantiferon gold/PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> NA	Tdap: _____	
	Zoster: _____	

NOTES:

- Thank you for referring your patient to UNC Hospitals Rheumatology Specialty Clinic. We kindly request that you be as complete as possible with referral information so your patient can be appropriately triaged and scheduled in a timely manner.
- The UNC Hospitals Rheumatology Specialty Clinic kindly requests that all patients have a primary care provider who will co-manage patients with UNC Hospitals Rheumatology Specialty Clinic providers.
- Primary Fibromyalgia, Ehlers-Danlos/Hypermobility syndrome, and Mechanical Back Pain patients will have a one-time consultation with detailed recommendations. Patient will follow-up with referring provider for future appointments.
- The UNC Hospitals Rheumatology Specialty Clinic will not manage chronic pain conditions with long-term narcotic medications.