



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):

LAST NAME:	FIRST NAME:	MIDDLE NAME:
PRIMARY PHONE:	ALTERNATE PHONE:	SEX: F <input type="checkbox"/> M <input type="checkbox"/>
BIRTH DATE:	RACE:	
STREET ADDRESS:		
CITY:	STATE:	ZIP:

CHECK SYMPTOM(S) / PHYSICAL EXAM FINDINGS

<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Skin Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Positive Serology
<input type="checkbox"/> Joint Stiffness	<input type="checkbox"/> Alopecia	<input type="checkbox"/> Uveitis / Scleritis	<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Abnormal Labs
<input type="checkbox"/> Joint Tenderness/Pain	<input type="checkbox"/> Mucosal Ulcers	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Morning Stiffness >1 hr	<input type="checkbox"/> Raynaud's	<input type="checkbox"/> Hemoptysis	<input type="checkbox"/> Paresthesia	<input type="checkbox"/> EDS/Hypermobility
<input type="checkbox"/> Joint(s) Involved:	<input type="checkbox"/> H/O Serositis	<input type="checkbox"/> Foot Drop	<input type="checkbox"/> Numbness	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Duration of Sx: _____	<input type="checkbox"/> Thrombotic Events	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chronic Back Pain
	<input type="checkbox"/> Miscarriages	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Fever	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Proteinuria	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Weight Loss	
	<input type="checkbox"/> Hematuria		<input type="checkbox"/> Abnormal Sleep	

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

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

REFERRING PHYSICIAN INFORMATION

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

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

POLICY HOLDER'S RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	LAST NAME:	FIRST NAME:
SEX: F <input type="checkbox"/> M <input type="checkbox"/>	BIRTH DATE:	PRIMARY PHONE:
PRIMARY INSURANCE CARRIER:	POLICY #:	GROUP #:
		EFFECTIVE DATE:
SECONDARY INSURANCE CARRIER:	POLICY #:	GROUP #:
		EFFECTIVE DATE: