UNC Hospitals Rheumatology Specialty Clinic
100 Eastowne Drive, Chapel Hill, NC 27514
Phone: (984) 974-4191; Fax (984) 974-0003

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 ☐ M ☐	BIRTH DATE:
RACE:	STREET ADDRESS:		
CITY:	STATE:	ZIP:	

CHECK SYMPTOM(S) / PHYSICAL EXAM FINDINGS

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

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: ☐SELF ☐PARENT ☐SPOUSE ☐CHILD ☐OTHER	LAST NAME:		FIRST NAME:
SEX: F ☐ M ☐	BIRTH DATE:		PRIMARY PHONE:
PRIMARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE:
SECONDARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE:

-Additional information on reverse side-