



# SAGINAW ARTHRITIS & RHEUMATOLOGY

ULTRASOUND & INJECTION CLINIC

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## Referral Form: Rheumatology

P: (989) 341-5078 | F: (989) 341-5073

### Locations

Caro    Bad Axe    Cass City    Saginaw

Thank you for choosing to refer your patient to us. Please include brief pertinent medical records and test results that support the consultation. Please call (989) 341-5078 regarding any questions.

Date: \_\_\_\_\_ From: \_\_\_\_\_

Number of Pages: \_\_\_\_\_ Title: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

### PATIENT INFORMATION

Name of Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ Interpreter needed:  Yes  No Language: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If Child, Name of Parent: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Insurance: Include patient's insurance card (both sides) and HMO authorization if required.

### CONSULTATION REQUEST INFORMATION

Diagnosis/ICD10: \_\_\_\_\_

Name of M.D. (if known): \_\_\_\_\_

Reason for Consultation: \_\_\_\_\_

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

### CONSULTATION REQUEST INFORMATION

Referring M.D.: \_\_\_\_\_ Specialty: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

PCP Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

**NOTICE OF CONFIDENTIALITY:** This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy, or otherwise disseminate any of the information contained herein.