SAGINAW ARTHRITIS & RHEUMATOLOGY
ULTRASOUND & INJECTION CLINIC

Anishka Rolle, MD, RhMSUS

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 Consulation: _____

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: _____