**REFERRING PROVIDER INFORMATION:**  
Referred by (MD, DO, NP, PA): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Medical Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION** (Please provide a copy of patient demographics)  
Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
DOB:\_\_/\_\_/\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F  
City/ State/ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Needs Interpreter? Y N Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Information:** (To avoid delay, use key below to assist in scheduling)  
Diagnosis (ICD-10 Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Physician requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**\*If requested Physician is unavailable, can Patient be seen by another provider?** Y N  
 **Consultation  2nd opinion**

|  |  |
| --- | --- |
| **Reason for Consult:** | |
| Ankylosing Spondylitis | Pseudogout |
| Fever of unknown origin | Psoriatic Arthritis |
| Gout | Rheumatoid Arthritis |
| IgG4 related disease | Sarcoidosis |
| Osteoarthritis/ Arthritis | Sjorgen's syndrome |
| Polymalgia Rheumatica | Steroid responsive hearing loss |
| Polymyositis/ Dermatomyositis | Systemic Lupus Erythematosus |
| Positive ANA | Vasculitis |
| If other, specify reason above |  |

**Please contact the following clinics for the services requested:**

|  |  |
| --- | --- |
| **Diagnosis:** | **Redirect to / Clinic Contact:** |
| **Chronic Fatigue** | Chronic Fatigue Clinic Ph: 650-736-5200 |
| **Ehlers Danlos Type III** | Pain Management Ph: 650-723-6238 or Physical Therapy Ph: 650-725-5106 |
| **Fibromyalgia/ Chronic Pain** | Pain Management Ph: 650-723-6238 (if no evidence of Rheumatologic Disease) |
| **IgA or IgG Subclass Deficiency** | Allergy Clinic Ph: 650-723-6961 |
| **Lyme Disease** | Currently unavailable |

**Include lab and imaging results for the following diagnosis:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Myositis** | **Osteoarthritis/ Arthritis** | **Rheumatoid Arthritis** | **Systemic Lupus Erythematosus** | **Vasculitis** |
| * CMP * CBC * Aldolase, CK, LDH | * Joint/ body specified * Common imaging | * CRP * ESR * CBC * CMP * RF * Anti-CCP * Common imaging | * CBC * CMP * U/A * +ANA & titer * dsDNA | * ANA * ANCA * U/A * Anti-protease 3 (pr3) * Anti-myeloperoxidase (MPO) * CRP * ESR * CBCD * CMP * Skin or Organ BX (in cutaneous vasculitis) |

**DOCUMENTATION REQUIRED** (Please fax with this form):

* **If patient has been seen by previous rheumatologist, include prior notes and pertinent labs diagnostic study reports**