**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 orPhysical 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**