Appalachian Orthopedics & Neurosurgery

A Member of the Campbell Clinic Orthopaedics Family

Rheumatology
REFERRAL REQUEST

The following must be received before the referral can be processed.

Patient Information

Patient name: _____ Date of birth: _____ SSN (last 4): _____

Address: _____

Primary phone: _____ Email: _____

Referring Provider

Referring provider: _____ Office phone: _____

UPIN / NPI: _____ Fax: _____

If the referring provider is not the PCP, list PCP and office phone: _____

We request that all patients have a primary care provider who will co-manage routine patient care.

Reason for Referral

Reason for referral / consult: _____

_____

Has the patient previously seen rheumatology? ☐ Yes ☐ No If yes, include previous notes, labs, and imaging.

Required Information Check each item included with this referral

☐ This completed consult / referral form

☐ Full patient demographics, including copies of insurance card(s), front and back

☐ Office visit notes within the past three months supporting diagnosis and reason for consult / referral

☐ Pertinent labs and imaging results

☐ Previous rheumatology records

☐ If the PCP is submitting a referral for another provider / specialist, records from that specialist

Required labs	All labs must be current, within 6 months of submission of the consult / referral		
☐ ANA with IFA / Titer	☐ Rheumatoid factor	☐ CCP	☐ CRP
☐ ESR	☐ CBC	☐ CMP	☐ Uric acid

If the above labs are unremarkable and the patient has extenuating circumstances, please have the referring provider contact the office to speak with one of our rheumatology providers.

Please Note

Our rheumatology clinic does not perform disability evaluations or functional capacity exams.

We do **NOT** usually see the following conditions, if isolated without a rheumatologic problem:

Fibromyalgia • Ehlers-Danlos syndrome • Mechanical back pain • Chronic pain • Chronic fatigue

Office Use Only

Date received		Referral approved by	
Appt date / time		New patient packet mailed	

Fax completed referrals to (855) 293-2014

CONSULT / REFERRAL SUMMARY WORKSHEET

Referral Summary

Patient name: _____ Date of referral: _____

Reason for consult / referral: _____ Previous referral submitted: ☐ Yes ☐ No

Previously diagnosed autoimmune disease(s): _____

Previous rheumatology providers: _____

Date labs obtained: _____ Date(s) of included chart(s): _____

Specialist Records Included

Check each specialty whose charts are in the consult / referral packet

☐ **Rheumatology** *(required if previously evaluated by rheumatology)*

☐ Dermatology ☐ Endocrinology ☐ Hematology / Oncology ☐ Neurology

☐ OB/GYN ☐ Ortho ☐ Optometry / Ophthalmology ☐ Pulmonology

Lab Results

Labs must be obtained within 6 months of referral

Check the result. Enter the actual value only if abnormal or positive.

Required Lab Results	
ANA	☐ Neg ☐ Pos
Titer	
Pattern	
RF	☐ Neg ☐ Pos _____
CCP	☐ Neg ☐ Pos _____
CRP	☐ Nml ☐ Abn _____
Sed Rate	☐ Nml ☐ Abn _____

Required if Possible Gout	
Uric Acid	☐ Nml ☐ Abn _____

Other Lab Results	
DsDNA	☐ Neg ☐ Pos _____
RNP	☐ Neg ☐ Pos _____
Smith	☐ Neg ☐ Pos _____
SM/RNP	☐ Neg ☐ Pos _____
Chromatin	☐ Neg ☐ Pos _____
SSA	☐ Neg ☐ Pos _____
SSB	☐ Neg ☐ Pos _____
SCL-70	☐ Neg ☐ Pos _____
JO-1	☐ Neg ☐ Pos _____
Centromere	☐ Neg ☐ Pos _____

Other Lab Results	
Ribosomal P	☐ Neg ☐ Pos _____
C3	☐ Neg ☐ Pos _____
C4	☐ Neg ☐ Pos _____
TPO	☐ Neg ☐ Pos _____
Thyroglobulin	☐ Neg ☐ Pos _____
Cardiolipin	☐ Neg ☐ Pos _____
HBV	☐ Neg ☐ Pos
HCV	☐ Neg ☐ Pos
CK	☐ Nml ☐ Abn _____

Other pertinent labs with results: _____

_____

Diagnostic imaging results included: _____

Significant past medical history: _____

For Rheumatology Office Use Only

Date of initial consult / referral review: _____ Reviewer: _____

All required items present for review to proceed: ☐ Yes ☐ No

If no, notify the referring provider that review cannot proceed, and why. If yes, submit / complete the final review.

Date of final review: _____ Reviewer: _____

Decision: ☐ Accepted ☐ Denied | ☐ BR ☐ JC ☐ Tele

If denied, reason: _____

_____

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