

NEW PATIENT REFERRAL FORM
Wake Forest University Baptist Medical Center
Dept of Internal Medicine – Section of Rheumatology and Immunology
Phone: (336) 716 – 4209 Fax: (336) 716 - 9821

****INFO MUST BE RECEIVED BEFORE APPOINTMENT WILL BE SCHEDULED.****

Patient Information:	MD Information:
Patient Name: (First, Middle, Last Sr/Jr...):	Name of Referring MD:
Baptist Medical Record # (if known):	Referring MD UPIN:
	Referring MD NPI#:
SS #: (if available):	Referring MD Phone Number: () -
	Referring MD Fax Number: () -
Sex: (Circle One) M F	Referring MD Address:
Race:	
Date of Birth: (mm/dd/yyyy) / /	Patient's Local Medical Dr (LMD):
Marital Status:	
Maiden Name (if applicable):	LMD Address:
Mother's First Name (For ID):	
Address:	LMD Phone Number: () -
	LMD Fax Number: () -
Home Phone: () -	Does the patient currently have a Rheumatologist? <input type="checkbox"/> No <input type="checkbox"/> Yes
Work Phone: () -	
Emergency Contact:	Has the patient been seen in WFUP Rheumatology previously? <input type="checkbox"/> No <input type="checkbox"/> Yes ; Year of last visit _____
Insurance Carrier:	Medical Center Employee: <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Fax copy of insurance card if available.</i>	<input type="checkbox"/> NCBH <input type="checkbox"/> WFUHS
Reason for Consult Request:	***Date Records Faxed: _____
<input type="checkbox"/> Abnormal serology; no minimal symptoms; test results:	<input type="checkbox"/> Regional pain disorder: Describe:
<input type="checkbox"/> SLE or Connective tissue disorder:	<input type="checkbox"/> RA or OA (Circle one):
<input type="checkbox"/> Inflammatory arthritis/ joint swelling:	<input type="checkbox"/> Diffuse pain syndrome:
<input type="checkbox"/> Muscle Disease:	<input type="checkbox"/> Other, Describe:

*****Request must be accompanied by faxed medical records for MD review.**