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ARTHRITIS and RHEUMATISM **CENTER**

www.achahalmd.com

1079 Eucalyptus Avenue, Suite A, Manteca, CA, 95337

PROVIDER REFERRAL REQUEST FORM

please fax completed form to: **209-284-4562**

REFERRING TO

Practice Name & Address: *Arthritis and Rheumatism Center*
1079 Eucalyptus Avenue, Suite A, Manteca, CA, 95337

Specialty: Rheumatology
Phone: 209-284-4561
Fax: 209-284-4562

Referring Provider's Name:	Phone:	Fax:

PATIENT INFORMATION

Patient Full Legal Name:	DOB: ___ ___ ___ (DAY MONTH YEAR)
Preferred Phone:	Best time to call:
Patient Insurance Information:	
Patient's Primary Care Provider:	Phone: Fax:

GENERAL INFORMATION

Reason for Referral (*Clinical Question*):

Comments/Considerations Related to Clinical Question:
Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes.

NOTES

____ pages of records are attached (insurnace info, labs, x-ray, office visit notes

Please attach patient's insurance card