



RHEUMATOLOGY CONSULTATION REFERRAL FORM

*** If your patient has not heard from us within 2 days of faxing this referral form,
Please have the patient call our referral coordinator at 770-284-3150***

PATIENT INFORMATION

PATIENT'S NAME: _____ DOB: _____

ADDRESS: _____

MAIN PHONE #: _____ 2ND PHONE #: _____

INSURANCE COMPANY: _____ INSURANCE ID#: _____

SELECT PROVIDER:

- | | | |
|--|---|---|
| <input type="checkbox"/> Dr. Jatin Patel (Roswell/Cumming) | <input type="checkbox"/> Dr. Serene Francis (Roswell/Suwanee) | <input type="checkbox"/> Dr. Omar Khan (Cumming) |
| <input type="checkbox"/> Dr. Taik Kim (Roswell/Suwanee) | <input type="checkbox"/> Dr. Naveen Raj (Woodstock) | <input type="checkbox"/> Dr. Alexandra Tiliakos (Suwanee) |
| <input type="checkbox"/> Dr. Mehrin Jawaid (Roswell/Cumming) | <input type="checkbox"/> Dr. Samuel Kim (Lawrenceville) | <input type="checkbox"/> Dr Anil Mankee (Suwanee) |
| <input type="checkbox"/> Dr. Ronak Vishnubhai Patel (Canton) | <input type="checkbox"/> Dr. Javeria Bhawal (Kennesaw) | |

LOCATION ADDRESSES:

Roswell: 11731 Pointe Place, Roswell GA 30076

Suwanee: 3921 Johns Creek Ct, Suite C, Suwanee, GA 30024

Canton: 120 Oakside Ct Suite C, Canton, GA 30114

Kennesaw: 4255 Wade green Rd NW, Suite 925, Kennesaw GA 30144

Cumming: 102 Mary Alice Park Rd, Suite 805, Cumming GA 30040

Woodstock: 300 Parkbrooke Pl, Suite 170, Woodstock, GA 30189

Lawrenceville: 601 Old Norcross Rd, Suite A Lawrenceville GA 30046

REFERRING PHYSICIAN INFORMATION

PHYSICIAN: _____

ADDRESS: _____

NPI#: _____

PHONE#: _____ FAX#: _____

CONTACT PERSON: _____ CONTACT PHONE/EXT: _____

_____ pages of records are attached (Insurance info, labs, x-ray, office visit notes)

Please include any lab or x-ray reports so that we don't duplicate testing

Reason for Consultation

- | | | |
|---|---|--|
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Gout/Pseudogout |
| <input type="checkbox"/> Positive ANA | <input type="checkbox"/> Abnormal labs | <input type="checkbox"/> Positive CCP testing* |
| <input type="checkbox"/> Lupus (SLE) | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Raynaud's |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Vasculitis | <input type="checkbox"/> Sjogren's (dry eye/mouth) |
| <input type="checkbox"/> Other: _____ <input type="checkbox"/> Diagnosis: _____ | | |

PLEASE ATTACH MEDICAL RECORDS & INSURANCE CARD. FAX THIS REFFERAL TO **404-509-5424**