

REFERRAL TO UK RHEUMATOLOGY

PATIENT INFORMATION

Last name _____ First name _____ Middle initial _____

Date of birth (month/day/year) _____

Address _____ Social Security number _____

Sex: Male Female _____ Phone number _____ Date of referral _____

Medical insurance: HMO PPO MediCare Medicaid Other _____ Amount of co-pay \$ _____

Insurance authorization number _____ Number of visits _____ Expiration date _____

Primary language: English Spanish Other _____ Translator required? Yes No

Referring provider information _____

Referring provider name title (MD, DO, ARNP, PA-C) _____

Phone number _____

Address _____

Fax number _____

City _____ State _____ Zip code _____

Contact name _____

How would you like us to communicate with you?

Phone: _____ Fax: _____ Email address: _____

Filling the following form will help in triaging and directing patients.

a) Does your patient have any of the following (for expedited referral/specialized clinic)?

- 1. Pulmonary fibrosis or interstitial lung disease
- 2. Renal disease related to lupus or scleroderma
- 3. Eosinophilic granulomatosis with polyangiitis (EGPA)
- 4. Granulomatosis with polyangiitis (GPA)
- 5. Giant Cell Arteritis/ Takayasu Arteritis
- 6. Unexplained cardiac failure
- 7. Unexplained renal failure
- 8. Autoimmune hearing loss
- 9. Autoimmune eye disease
- 10. Unexplained stroke
- 11. Finger ischemia

b) Reason for referral (choose main one)

- 1. ANA by IFA (Anti-nuclear antibodies by indirect immunofluorescence)
Please Mark pattern (nucleolar, centromere, other)
Titer _____
- 2. Rheumatoid factor
Note: Hepatitis C is the most common cause of a false positive RF.
- 3. Anti-CCP (Anti-cyclic citrullinated peptide)
- 4. Inflammatory joint pain (Joint pain that decreases with activity)
- 5. Creatine Kinase elevation three times normal or with objective weakness.
- 6. Osteoarthritis (Joint pain that increases with activity)
*We evaluate this diagnosis but defer management to primary provider.
*We suggest referral to Pain Management Clinic, Orthopedics, or Physical Medicine & Rehabilitation
- 7. Fibromyalgia
*We evaluate this diagnosis but defer management to primary provider.
- 8. Elevated ESR and CRP
(Please send more records to Fax (859)218-7511 for review before scheduling)
- 9. Other:
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