Rheumatology Referral Form

Thank you for your referral. Please provide the information requested below.

FAX the completed form AND copies of recent office visits, medication and allergy list, relevant lab/diagnostic tests, patient demographics, and a copy of patient insurance cards to the fax number: 515-270-7202.

Reason for Referral

☐ Physician Consultation (Continue with the Remainder of the Form)

☐ DEXA/Bone Density (Complete this form through the insurance section. Attach **DEXA Order** separately.)

Name:____________________ DOB:____________ ☐ Male ☐ Female

Address:____________________ City:__________ State:____ Zip:_____

Phone:____________________ Second Phone:____________________

PCP:____

Insurance (include copy of card):______________________________

****Patients with UHC Navigate, Humana HMO, and Tricare Active/Tricare West require authorizations!! Please provide authorization so we can schedule. ****

Auth #:__________ **# of Visits Authorized**:__________ **Time Span Authorized**:__________

Referring Provider:____

Clinic Address:____

Phone:____________________________ Fax:____________________

Office Contact:____

Has Patient Previously Seen a Rheumatologist? ☐ Yes ☐ No

****If this is a DEXA referral, the form is completed here. Please attach your DEXA order form to this sheet. ****

Referring Provider: Please ***CHOOSE ONE*** of the following categories/reasons for this Rheumatology referral. Check mark it ***and*** provide additional information as requested.

☐ **Inflammatory Arthritis (Rheumatoid Arthritis, Psoriatic Arthritis)**

- ☐ Exam Shows Swollen Small Joints (Hands, Feet, Etc)
- ☐ Exam Shows Swollen Large Joints (Knees, Shoulders, Etc)
- ☐ RF+______________________________
- ☐ CCP+______________________________
- ☐ Elevated CRP:______________________________
- ☐ Elevated ESR:______________________________

☐ **Osteoporosis (Must Provide DEXA Images and Results if Completed in Past)**

- ☐ Bone Density Date:______________________________
- ☐ Previous and Current Therapy: ______________________________

Iowa Arthritis and Osteoporosis Center Rheumatology Referral

☐ **+ANA (Must Provide Clinical Symptoms or Lab Abnormalities)**

☐ Pleurisy ☐ Proteinuria ☐ Malar Rash ☐ Photosensitivity
☐ Pericarditis ☐ Kidney Disease ☐ Recurrent Fevers ☐ Sicca Symptoms
☐ Cytopenias ☐ Joint Pain ☐ Swollen Joints ☐ Other________________ ________________
☐ +dsDNA ☐ Scleroderma Skin ☐ Raynaud's

☐ **Ankylosing Spondylitis (Spondyloarthropathies)**

- ☐ Prominent Nocturnal Pain/Awakening at Nigh
- ☐ AM Stiffness > 1 Hour
- ☐ Elevated ESR or CRP
- ☐ HLA-B27+
- ☐ Responsive to NSAIDs

☐ **Giant Cell Arteritis**

- ☐ Elevated ESR/CRP:____
- ☐ Onset of Symptoms:____
- ☐ Steroid Started: When?____________________ Dose:________________________
- ☐ Temporal Artery Biopsy Done? ☐ Yes ☐ No

☐ **Systematic Vasculitis**

☐ Lungs ☐ Kidneys ☐ Skin ☐ Nervous System ☐ Other: ________________

- ☐ Onset:____
- ☐ Abnormal Labs:____
- ☐ Any Other Concerns:____

☐ **Crystalline Arthritis (Gout, Pseudogout)**

- ☐ Joints Involved: ____
- ☐ Therapies Already Tried:_______________________________________
- ☐ Crystals Previously Documented? ☐ Yes ☐ No

☐ **Osteoarthritis**

- ☐ Please List *Specific* Goals: Confirm Dx, Joint Injections, Other: ______________________

☐ **Fibromyalgia/Chronic Pain Syndrome**

- ☐ Patient may be seen for a ***one time only*** consultation to confirm diagnosis, exclude other issues, educate, and make management ***recommendations back to the referring provider***.

☐ **Other:** ____
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Scheduled Appointment Date:________________Time:______________With Doctor:_____________________ ___________