

Rheumatology Referral Form

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

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

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: _____

Translator needed: Yes or No What language: _____

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: _____ NPI# _____

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: _____

Osteoarthritis

Please List *Specific* Goals: Confirm Dx, Joint Injections, Other: _____

Iowa Arthritis and Osteoporosis Center Rheumatology Referral

Osteoporosis (Must Provide DEXA images for review, will not schedule without the images)

- Bone Density Date: _____
- Previous and Current Therapy: _____

+ANA (Must Provide Clinical Symptoms or Lab Abnormalities)

- | | | | |
|---------------------------------------|---|---|---|
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Proteinuria | <input type="checkbox"/> Malar Rash | <input type="checkbox"/> Photosensitivity |
| <input type="checkbox"/> Pericarditis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Recurrent Fevers | <input type="checkbox"/> Sicca Symptoms |
| <input type="checkbox"/> Cytopenia | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> +dsDNA | <input type="checkbox"/> Scleroderma Skin | <input type="checkbox"/> Raynaud's | |

Ankylosing Spondylitis (Spondyloarthropathies)

- Prominent Nocturnal Pain/Awakening at Night
- 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

Systemic 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

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: _____

