McFarland Clinic

Rheumatology Referral Form

Thank you for your referral. **Before completing this form, read thoroughly and fill out appropriately.** Please 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 **515-956-4010.**

Referral Date:______________ Referral Diagnosis w/ ICD-10 code :________________________

Patient Name:____________________________________ MRN (internal):__________________

Address:____ DOB:____________________

City, State, Zip:____

Home #: ___________________ Mobile #: _________________ Work #: ___________________

Email: _________________________ Preferred Language: ______________________________

Insurance (please include copy of card):____

If authorization required: Auth #:_______________ # of Visits Authorized:_____________

Time Span Authorized:______________________

PCP:____

Referring Provider:____

Clinic Address:____

Phone #:_____________________________________ Fax #:_________________________

Office Contact:____

Has the patient previously seen a Rheumatologist? _______________

If so, where? ____

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+
  - ☐ Elevated CRP
  - ☐ CCP+
  - ☐ Elevated ESR
- ☐ **Osteoporosis** (Please provide **DEXA** scan results/images) *required
  - ☐ *Bone density date ____/_____/_____
  - ☐ Previous and current therapy
- ☐ **+ANA** (Must provide clinical symptoms or lab abnormalities)
  - ☐ Pleurisy
  - ☐ Percardarditis
  - ☐ Cytopenias
  - ☐ +dsDNA
  - ☐ Proteinuria
  - ☐ Kidney disease
  - ☐ Joint pain
  - ☐ Scleroderma skin
  - ☐ Malar rash
  - ☐ Recurrent fevers with no origin
  - ☐ Swollen joints
  - ☐ Raynauds
  - ☐ Photosensitivity
  - ☐ Sicca symptoms
  - ☐ Other ____
- ☐ **Ankylosing Spondylitis** (Spondyloarthropathies)
  - ☐ Prominent nocturnal pain/ awakening at night
  - ☐ AM stiffness >1 hour
  - ☐ Elevated ESR and CRP
  - ☐ +HLA-B27
  - ☐ Responsive to NSAIDS
- ☐ **Giant Cell Arteritis**
  - ☐ Elevated ESR and CRP
  - ☐ Onset of symptoms ________________________________
  - ☐ Steroids started: When? _____________________________
  - ☐ Temporal artery biopsy done?
- ☐ **Systemic Vasculitis**
  - ☐ Lungs
  - ☐ Kidneys
  - ☐ Skin
  - ☐ Nervous System
  - ☐ Other ________________________________
  - ☐ Onset: ____
  - ☐ Abnormal labs:____
  - ☐ Any other concerns:____
- ☐ **Gout/ Pseudogout**
  - ☐ Joints involved:_______________________________________
  - ☐ Therapies already tried:_________________________________
  - ☐ Crystals previously documented?:__________________________

- ☐ **Osteoarthritis**
  - ☐ Please list specific goals: Confirm dx, joint injections, other: ____________________
- ☐ **Fibromyalgia - ONLY W/ ABNORMAL LABS**
  - ☐ Will seen for a **ONE time only** consultation to confirm diagnosis, exclude other issues, educate, and **make management recommendations back to the referring provider**
- ☐ Other:____________________
  ____
  ____________________.

<u>Please be aware:</u> We do NOT see: Ehlers-Danlos Syndrome, Hypermobility, Chronic Fatigue, Vitamin D Deficiency, Chronic pain (without abnormal labs).

***** Please call our office if you have any questions regarding a diagnosis & if we are able to see it.*****