RHEUMATOLOGY CLINIC CONSULTATION FORM
Louisiana State University Health in Shreveport (LSUHSC-S)
FAX 318-675-6980 PHONE 318-675-5930
(FOR USE BY PHYSICIANS OUTSIDE OF LSUHSC-S)

Patient Name:_____ Date of Birth:_____

Address:_____ Social Security#:_____
_____ Insurance/Medicare/Medicaid:_____
Telephone:_____ _____

Please do not refer pain patients to us, WE DO NOT PRESCRIBE PAIN MEDICATIONS; we need to see current labs and x-rays for each patient. (and notes)

Please Send One referral.

Reason for Referral:

Fever	**Y/N**	**Duration:**
Rash	**Y/N**	
Joint Pain	**Y/N**	**Location:**
Joint Swelling/Limitation of motion		**Y/N**
Muscle pain/Weakness	**Y/N**	
Skin Tightness	**Y/N**	
Other		

Referring Physician:_____

Referring Physician's
UPIN#:_____NPI#_____

Address:_____
_____
_____

Telephone: (_____)_____

Fax:_____

I currently provide primary care medical services for this patient and will continue to provide these primary care services. _____Yes _____No
If no, patient must have referral from their primary care physician who will provide continuity of care after consultation.

_____ _____
Physician Signature Date

Mail or Fax completed form and patient records to:
Arthritis Center- Section of Rheumatology
LSU Health Sciences Center
P.O. Box 33932
Shreveport, LA 71130-3932