RHEUMATOLOGY & OSTEOPOROSIS CENTER of Memphis

Records required for Referral:

- Recent office notes (required)
- Lab Reports (if applicable)
- Imaging / Diagnostic Reports (if applicable)
- Copy of Insurance Card (required)
- Demographics Page (required)

NEW PATIENT FAX REFERRAL FORM

(fields marked ** are required)

****Diagnosis / Reason for referral**: _____

****Has the patient been seen by a Rheumatologist previously**? (circle) YES NO

If YES, please list Name of Doctor and year last seen: _____

****Requested Provider**: ____ Dr. David Boatright ____ Dr. Hugh Holt ____ Dr. Yamini Menon ____ 1ST Available

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Patient Information

**Patient Name: _____ **DOB: _____ M___ F ____

**Address: _____

**City/State: _____ **Zip: _____ **SSN: _____

**Primary Phone: _____ Alternate Phone: _____ email: _____

**Does this patient have any communication, language or special needs? _____

Patient Insurance (please send a copy of the front and back of the patient insurance)

**Primary Insurance: _____ **ID / Group: _____ Subscriber: _____

Second Insurance: _____ ID: _____ Subscriber: _____

Referring Provider Information:

**Name: _____ NPI: _____

Address: _____

**Office Contact: _____ email: _____

**Direct Phone: _____ **Office Phone: _____ **Office Fax: _____

Please fax this form, along with the records requested above, to 901-309-5008

Please contact the office at 901-309-5000 with any questions.