BAY ARTHRITIS INSTITUTE

PLEASE COMPLETE THIS FORM AND FAX TO (850) 215-3024

PT NAME: _____ DOB: _____

ADDRESS: _____

_____

HOME #: _____ CELL #: _____

REFERRING DR: _____

OFFICE ADDRESS: _____

_____

PHONE #: _____ FAX #: _____

NPI: _____ MCD #: _____

REASON FOR THE REFERRAL:

- ☐ JOINT/MUSCLE PAIN
- ☐ RHEUMATOID ARTHRITIS
- ☐ PSORIATIC ARTHRITIS
- ☐ LUPUS
- ☐ GOUT
- ☐ SJOGREN'S
- ☐ ABNORMAL LAB RESULTS
- ☐ OTHER: _____
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ RAYNAUD'S
- ☐ FIBROMYALGIA
- ☐ VASCULITIS
- ☐ POLYMYALGIA RHEUMATICA
- ☐ SCLERODERMA

PLEASE FAX DEMOGRAPHIC SHEET, COPY OF INS CARD(S), OFFICE NOTE,
AND MOST RECENT LAB/IMAGING REPORTS.

WE HAVE SCHEDULED YOUR PATIENT ON _____ AT _____ AM/PM

YOUR PATIENT HAS BEEN CONTACTED REGARDING THIS APPOINTMENT.

THANK YOU FOR TRUSTING ME WITH THE CARE OF YOUR PATIENT.

2917 Hwy 77 • Panama City, FL 32405 • WWW.BAYARTHRITIS.COM • 850-215-3062 • fax 850-215-3024