Consultation Request Form

ASHEVILLE ARTHRITIS AND OSTEOPOROSIS CENTER, P.A.
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Date:

Physician Requesting Consultation:

Specialty:

Practice Name and Address:

If Advanced Practice Provider refers, please list supervising Physician:

Practice Phone: Fax:

NPI: Contact:

Reason for Consultation:

Patient Name:

Address: City: State: Zip:

Date of Birth: Phone: Social Security:

Employer:

Primary Insurance Company: Policy #:

Secondary Insurance Company: Policy #:

Carolina Access:

*We must have a copy of insurance cards before we can schedule an appointment

Interpreter Needed: ☐ Language:

Physicians wishing to refer patients for evaluation and management of rheumatologic disease are requested to send:

- ❑ Recent office or hospital note documenting:
  - History
  - Review of systems
  - Medication list
  - Physical exam
  - Assessment and plan
- ❑ Labs, radiology, or other data relevant to the referral.
- ❑ If a patient has previously been diagnosed with a rheumatologic condition, please send pertinent records if available.