

RHEUMATOLOGY CONSULT ORDER FORM

Submit online or obtain more forms at [laccheo.com/consult](http://laccheo.com/consult)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's phone numbers:

Mobile: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Reason for consult:

---

---

---

- ☐ Second opinion: \_\_\_\_\_ (send prior rheumatologists notes)
- ☐ Abnormal lab: \_\_\_\_\_ (send a copy of the lab(s))
- ☐ Prior established diagnosis: \_\_\_\_\_ (send prior rheumatologist notes)

Ordering MD/DO/ARNP/PA: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Provider signature: \_\_\_\_\_

**\*\*\*Please fax or electronically submit all relevant clinical notes, labs and radiographs including prior evaluations by other rheumatologists in order to avoid duplicate testing and delayed treatment.\*\*\***

Thank you.



---

**For use by MTMG staff only**

Appointment Info:

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm By: \_\_\_\_\_ (initials)

Patient informed for appointment: ☐ Yes ☐ No By: \_\_\_\_\_ (initials)

Referring office informed of appointment: ☐ Yes ☐ No By: \_\_\_\_\_ (initials)