COLUMBUS ARTHRITIS CENTER
Leaders in Rheumatology Care since 1955.

Referral Form – Fax to (614) 486-9665 or e-mail to referral@columbusarthritis.com

Referring Physician: _____ Date: _____ Completed By:_____

Referring Office Phone #:_____ Fax #:_____

Patient Name: _____ SS#: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Mobile #: _____

Insurance: _____ Does insurance requires a referral? Yes/No (if yes, please attach a copy of referral)

Please send the following information with your completed referral:

Copy of the patient's insurance card (front and back)
Any relevant medical records

Referral For:

- □ Office Consultation
- □ Infusion (include order)
- □ Other:_____

Patient Scheduling:

- ☐ Emergency – **PLEASE FAX FORM & CALL OUR OFFICE TO SCHEDULE**
- ☐ Urgent (Within 1 to 2 weeks)
- ☐ Next Available

Reason For Referral (Diagnosis or Symptoms): _____

Referred to:

- □ Any Physician

Specific Physician:

- ☐ _____

Please fax all completed referral forms to (614) 486-9665 or e-mail to referral@columbusarthritis.com.
For questions or to reach our central scheduling department directly, please call (614) 486-5200

COLUMBUS ARTHRITIS CENTER, INC. USE ONLY:
Contact Log:

_____ _____ _____

- □ **Patient Scheduled**
  Date/Time of Scheduled Visit: _____/_____ Physician Name:_____
  Thank you for your referral! We appreciate the opportunity to participate in your patient's care.
- □ **Patient Not Scheduled**
  Reason:_____
  Thank you for your referral! However, we have been unsuccessful in scheduling this patient. Please contact the patient for the appropriate follow-up. Feel free to call our office with any questions.
  Completed By:_____ Date Faxed to Referring Physician:_____

9-15-10