



Rheumatology Consultation Request

PATIENT INFORMATION			
Last Name	First Name	Middle Initial	Address
Date of Birth	Social Security Number:	Phone Number:	City
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Medical Insurance:	Amount of Co-Pay:	State Zip
Insurance Authorization #:	# of Visits:	Expiration Date:	

It may be necessary for some patients to be seen by a Nurse Practitioner: Does the patient or provider object? YES NO

Required Information Physician Note Recent Lab Results X-ray Results Other _____

Not supplying this required information will delay processing of your request
NOTE: Patient must bring X-ray films with them the day of appointment.

Diagnosis or symptoms:	Primary Language:	Translator Required:
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REFERRING PHYSICIAN INFORMATION			
Referring physician:	Title: (MD, DO, ARNP)		Address:
City	State	Zip Code	Phone Number:
Contact Name:	Contact Email: <i>Confirmation will be emailed if address supplied.</i>		Fax #
<input type="checkbox"/> Please Fax a copy of the acceptance letter to UK Access Center Contact Name:	UK Access Fax # 606-256-1259		

Please fax this information to:

Attn: Rheumatology Intake Coordinator
 740 S. Limestone, J515
 Lexington, KY 40536-0284
 Phone: 859-323-6700
 Fax: 859-257-8258

Note: Due to the amount of referrals and, demand outstrips our capacity, it is necessary that all new referrals be triaged by our rheumatologists. Therefore, it could be up to seven (7) working days before your office receives a response. Supplying an email address will ensure you receive a confirmation of receipt.