



REQUEST FOR CONSULTATION

COASTAL RHEUMATOLOGY ASSOCIATES

5400 Waters Avenue ▪ Savannah, GA 31404

Phone 912/349-4227 ▪ Fax 912/349-4457

www.coastalrheumatology.com

Please be sure to send recent office notes with any pertinent lab/imaging reports

Fax along with this completed form our new patient referral fax line: 912/330-1156

PATIENT INFORMATION

Name _____ DOB ____/____/____
(first, middle, last)

Address _____

City _____ State _____ ZIP _____

Parent/Guardian _____

Patient's Day Phone () _____ Mobile Phone () _____

Email Address _____

PRIMARY INSURANCE (copy of insurance card must be attached) _____

Policy Holder's Name _____

Policy # _____

SECONDARY INSURANCE (copy of insurance card must be attached) _____

Policy Holder's Name _____

Policy # _____

REFERRING PHYSICIAN INFORMATION

Name _____ Referring Provider's NPI _____

Address _____ Phone () _____

City _____ State _____ ZIP _____ Fax () _____

Name of Contact Person _____

REASON FOR REFERRAL _____

Thank you for your kind referral. We appreciate the opportunity to provide service to your patient.

INTEROFFICE USE: Date of Appointment _____ Time _____ AM/PM

Scheduled by _____ Date Scheduled _____

Referring MD notified of appointment? Yes No By _____