



Pinehurst Medical Clinic

R H E U M A T O L O G Y

**Please fax completed form and pertinent records to PMC Rheumatology at
910-255-0060**

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	SEX: F <input type="checkbox"/> M <input type="checkbox"/>	MIDDLE NAME:
PRIMARY PHONE:	ALTERNATE PHONE:		BIRTH DATE:
RACE:	STREET ADDRESS:		
CITY:	STATE:	ZIP:	

CHECK SYMPTOM(S) / PHYSICAL EXAM FINDINGS

<input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Joint Tenderness/Pain <input type="checkbox"/> Morning Stiffness >1 hr <input type="checkbox"/> Joint(s) Involved: _____ <input type="checkbox"/> Duration of Sx: _____ _____	<input type="checkbox"/> Skin Rashes <input type="checkbox"/> Alopecia <input type="checkbox"/> Mucosal Ulcers <input type="checkbox"/> Raynaud's <input type="checkbox"/> H/O Serositis <input type="checkbox"/> Thrombotic <input type="checkbox"/> Events <input type="checkbox"/> Miscarriages <input type="checkbox"/> Proteinuria <input type="checkbox"/> Hematuria	<input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Uveitis / <input type="checkbox"/> Scleritis <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Foot Drop <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Dysphagia <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Paresthesia <input type="checkbox"/> Numbness <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Abnormal Sleep	<input type="checkbox"/> Positive Serology _____ <input type="checkbox"/> Abnormal Labs _____ <input type="checkbox"/> Chronic Pain <input type="checkbox"/> EDS/Hypermobility <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic Back Pain <input type="checkbox"/> Other: _____
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LIST PREVIOUSLY EXISTING RHEUMATOLOGIC DIAGNOSIS IF APPLICABLE:

SPECIFIC QUESTION(S) TO BE ADDRESSED:

Is this for a second opinion? Yes No

REFERRING PHYSICIAN INFORMATION

PHYSICIANS NAME:		
PRACTICE NAME:		
STREET ADDRESS:		CITY, STATE, ZIP
PHONE:	FAX:	EMAIL ADDRESS:

INSURANCE POLICY HOLDER INFORMATION (PLEASE ALSO ENCLOSE COPY OF INSURANCE CARD)

POLICY HOLDER'S RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		LAST NAME:	FIRST NAME:
SEX: F <input type="checkbox"/> M <input type="checkbox"/>	BIRTH DATE:		PRIMARY PHONE:
PRIMARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE:
SECONDARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE:

*Additional information on the
following page.*

NOTES:

- Thank you for referring your patient to Pinehurst Medical Clinic (PMC) Rheumatology Department. We kindly request that you be as complete as possible with referral information so your patient can be appropriately triaged and scheduled in a timely manner. Pertinent records may include: office notes, relevant labs, imaging, and discharge summaries.
- The PMC Rheumatology Department kindly requests that all patients have a primary care provider who will co-manage patients with the PMC Rheumatology clinic providers.
- The PMC Rheumatology Department will not manage chronic pain / chronic lower back pain conditions with long-term narcotic medications.
- The PMC Rheumatology Department does not accept Medicaid at this time. Please visit www.pinehurstmedical.com for a full list of accepted insurances.