** REFERRAL FORM**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Fax completed form and patient information to (205) 444-4856

**Inflammatory Back Pain**

**Referral Criteria**

Differentiate Inflammatory Back Pain VS Mechanical Back Pain using IPAIN (> 3 Months)

**Check all that apply**

**[ ] I** – Insidious onset

**[ ] P** – Pain at Night

**[ ] A** – Age < 40 years

**[ ] I** – Improves with exercise

**[ ] N** – No Improvement with rest

**Inflammatory Back Pain Testing**

**[ ]** **HLAB27** positive

**[ ]** **ESR** Erythrocyte

Sedimentation Rate

**[ ]** **CRP** C-reactive Protein

**PsA**

**Referral Criteria**

P - Painful Swollen Joints

S - Stiffness, Sausage fingers

A - Axial Spine / Back Pain

(Improves with activity)

**Check all that apply**

**[ ]** Evidence of Psoriasis

**[ ]** Psoriatic Nail Dystrophy

(Onycholysis, Pitting, Hyperkeratosis)

**[ ]** Sausage Digit (Dactylitis)

**PsA Testing**

**[ ]** **RF** Rheumatoid Factor

**[ ]** **ESR** Erythrocyte Sedimentation Rate

**[ ]** **CRP** C-reactive Protein

**Joint Pain / RA**

**Referral Criteria**

RA may be suspected if a patient has symptoms lasting > 6 weeks AND any of the following are true:

**Check all that apply**

**[ ]** Swollen joints (> 1 small joint or > 2 large joints

**[ ]** Positive squeeze tests

**[ ]** Morning Stiffness

**Rheumatoid Arthritis Testing**

**[ ]** **RF** Rheumatoid Factor

**[ ]** **Anti-CCP** Anticyclic Citrullinated Peptide Antibody

**[ ]** **ESR** Erythrocyte Sedimentation Rate

**[ ]** **CRP** C-reactive Protein

Reason for referral\*:

**\*Not taking OA or FM** [ ] ROUTINE [ ] URGENT

[ ] Rheumatoid Arthritis / Joint pain [ ] Psoriatic Arthritis / PsO [ ] Sjogren’s / SLE

[ ] Inflammatory Back Pain / Ankylosing Spondylitis [ ] Abnormal Labs [ ] Other

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Does this patient have a Current Rheumatologist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_(NAME)** **Information needed with referral**

[ ] This Referral Form [ ] Prior Rheumatology records

[ ] Notes on patient history, Assessment and Diagnosis [ ] All lab tests and Radiology reports

**Patient Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please send copy of patient’s insurance\*

**\*not accepting Health Springs, Medicaid, UHC or any**

**Medicare Replacement plans**

**Referring Physician Information**

Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician NPI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_