NAME:

MR #

DOB

FIN:

Patient Identification

EASTERN MAINE MEDICAL CENTER
Rheumatology Specialists

33 Whiting Hill Road, Suite 34
Brewer, ME 04412
207.973.9887

NEW PATIENT CONSULTATION REFERRAL

Please complete this form entirely* and forward to EMMC - Rheumatology

Fax # **207-973-9777**

*All sections need to be completed before an appointment can be made.
This request will be reviewed by our physician staff.
You will be called with the next available appropriate appointment.

Please Fax Office Lab / Imaging / Pathology Result Along with Referral

Date of Referral: _____ Primary Care Provider: _____

Referring Provider: _____ Phone:_____ Fax:_____

Patient Name: (Last, First, - please print)	**Date of Birth:**
	EMMC MR (if known)
Address:	**Phone Number:**

Reason for Referral:

Referring to:

☐ **Rheumatology**

☐ **MD spoke with**_____**MD/DO on** _____

Insurance:

Primary _____

Contract # _____ Group # _____

Secondary _____

Contract # _____ Group # _____

Medicare Part D _____

☐ FAX insurance referral (non-Medicare)

RAMC Use Only	**Referral to MD** (date):
	Returned (date):

Appointment Date / Time / MD:

Appt Scheduled by:

Referring Office Notified (date / time):

☐ Packet Sent ☐ Pt. Called

Provider Signature _____

Printed Name _____

Date_____ Time _____

Per Provider Schedule

Appointment - ☐ Next Available ____Weeks ____Months

Please return records with this form ☐ **Records Returned**

100002450

(11/20/15)