Michigan Rheumatology
RAFIA KHALIL, M.D.

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PHYSICIAN REFERRAL FORM

Clinical Information: Please note that a Rheumatology scheduling secretary will be contacting the patient directly to make the appointment based upon the information on this sheet, 1-2 days upon receipt of the below listed information.

In order for appointment to be scheduled, all pertinent office notes, labs and x-ray reports need to be mailed or faxed (810-985-3700). *X-ray files to be hand-carried by patients.*

PLEASE NOTE:

Patients not consulted for RA, Lupus, Sarcoidosis or any condition requiring toxic treatment, will be returned to their Primary Care Physician for management after three (3) visits.

Patient Information

Name:_____ DOB:____/____/_____ SSN:_____–_____–_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Address:_____ Insurance:_____

Referring Provider Information

Name: _____

Phone: _____ Fax: _____

Address: _____

Specific Question to be answered by consult: _____

_____

_____

Tentative Diagnosis: _____

Length of time patient has had symptoms: _____

Data previously obtained to evaluate symptoms: _____

_____

Test Results RF:_____ ANA:_____ CRP:_____ SED RATE:_____ Other:_____

Prior Rheumatology Consults: Yes_____ No_____

How soon does the patient need to be seen? 1 weeks____ 2 weeks____ 3 weeks____ 4 weeks____

Due to the nature of Rheumatology, Dr. Khalil may need to refer patients to other medical providers for further evaluation. ***Does the referring physician have physician preferences in the following areas that he/she prefers their patients to be sent to?*** Yes ____ No____

If Yes, please provide the following the referring physician's preferences:

Specialty	Name	Office #	Specialty	Name	Office #
Neurologist			Orthopedic		
Dermatologist			Ophthalmology		