



**GARNER RHEUMATOLOGY
& INFUSION CENTER**

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Fax 1-833-450-7300
www.garnerrheumatology.com

REFERRAL FORM

Please fax this referral form to **1-833-450-7300** along with most recent office notes, results of labs and imaging studies, demographics, and copy of insurance card.

Referral Date _____

PATIENT INFORMATION

Name (first, last) _____ D.O.B _____

Address _____ City _____ Zip _____

Phone _____ Email _____

REFERRAL INFORMATION

Physician Name _____ Practice Name _____

Office Contact Name _____ Office Phone _____ Fax _____

Reason for Consult/Diagnosis _____

PRIMARY CARE PHYSICIAN

Name _____ Phone _____ Fax _____

INSURANCE INFORMATION

Primary Insurance _____ Group ID# _____ Member ID# _____

Primary Card Holder's Name _____ DOB _____ Relation _____

Secondary Insurance _____ Group ID# _____ Member ID# _____

Primary Card Holder's Name _____ DOB _____ Relation _____

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