GARNER RHEUMATOLOGY
& INFUSION CENTER

810 Timber Drive, Garner, NC 27529
Tel. 919-747-9040
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_____
