APPALACHIAN REGIONAL RHEUMATOLOGY
a practice of Appalachian Regional Medical Associates

Patient Name_____
Date of Birth_____
MRUN_____
Please Fill in or Affix a Patient Label

Appalachian Regional Rheumatology
2146 Blowing Rock Rd | Boone, NC 28607
Phone| 828.386.2300 Fax| 828.386.2301

Referral Form

Date:_____ Referring Office Contact Person:_____

Referring Physician:_____

Telephone #:_____ Fax #:_____

Reason for Referral:_____

PATIENT INFORMATION

Patient Full Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home phone #:_____ Daytime phone #: _____

Last 4 Digits of SSN:_____ DOB:_____ Gender ☐Male ☐Female

INSURANCE INFORMATION

Insurance Name/Type:_____

Group#:_____ ID#:_____

MEDICAL HISTORY

Has the patient had prior lab work? ☐ Yes ☐ No

Has the patient seen a Rheumatologist? ☐ Yes ☐ No

Comments: _____

(Please fax completed form along with copies of the above studies, reports, and pertinent office notes to fax number (828) 386-2301)

APPOINTMENT INFORMATION *(FOR ARR USE ONLY)*

☐Patient aware of appointment ☐Unable to contact patient

Appointment date:_____ Time:_____ am / pm

Physician:_____ Location:_____

Effective Date: Not Set
Revised Date: 11/16/2020
Form Number: 11680

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