MUSC Health
MUSCULOSKELETAL INSTITUTE

* Required Fields

NEW PATIENT REFERRAL CHECKLIST

MUSC Rheumatology

***Referral to (if physician preference): ____**
*** Patient Name: ___________________________________ *DOB: ___________________**
*** SS#:** _______________________ MUSC MRN (if applicable): _____________________
***Address: ____**
*** Cell Ph #: ___________________**
Home Ph #: __________________ Email: _________________________________
Alternate Contact Ph #: ____________________ Relation to Patient: _________________
__ Insurance: Provider Name ________________________ ID#________________
__ MEDICAID or MEDICARE: Policy/Group# _________________
__ Self Pay __ Disability

*** Referring Physician:_________________________ *Specialty:_____________________**
*** Office Address:_______________________ * Ph#: ____________ Fax#: ____________**
____

Patient's Primary Care Physician: ____________________________ Phone #: ______________

Reason for Referral: ____
Additional Patient History: ____
____
Physician Preference: _____________________________ First Available: ________________

*** In order to provide timely scheduling for your patient please call 843-792-9200 to obtain date & time of your patients appointment. Then, please Fax the Following Reports & Records if applicable, to 843-792-2995:**

☐ Office Notes	☐ Medication List	☐ Lab Results	☐ ECHO	☐ PFTs	☐ Imaging Reports: CT MRI
☐ Other (e.g., Skin biopsy, Dermatology, etc.): ______________________________________					

*** REQUIRED * We MUST be able to view pertinent radiology imaging at time of visit. Patients are required to bring any other outside imaging on CD(s) with them to their first appointment (Please Choose One)**

- ☐ N/A - patient has not had any imaging yet or imaging has been performed at MUSC
- ☐ Patient has been instructed to pick up CD from performing facility (hospital, etc.)
- ☐ Patient given copy a CD by your office (patient must bring this with him/her to appt)

*** Completed by: _______________________ Ph#: _____________ Date: _____________**