Print Reset Form Fields

MUSC Health
MUSCULOSKELETAL INSTITUTE

* Required Fields

NEW PATIENT REFERRAL CHECKLIST

MUSC Rheumatology Scleroderma Center

*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: _____
* Please skip this section if patient already registered in MUSC system:
__ Insurance: Provider Name _____ ID#_____
__ MEDICAID or MEDICARE: Policy/Group# _____
__ Self Pay __ Disability

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* Referring Physician:_____ *Specialty:_____
* Office Address:_____ * Ph#: _____ Fax#: _____
_____
Patient's Primary Care Physician: _____ Phone#: _____

Reason for Referral: _____
Additional Patient History: _____
_____

* Please Fax the Following Reports & Records if applicable, to 843-792-0660:

☐ Full Demographic ☐ Office Notes	☐ Lab Results	☐ ECHO	☐ PFTs	☐ Imaging Reports	☐ Cardiac Cath
☐ Other (e.g., Dermatology, Pathology, 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: _____