BELLINGHAM ARTHRITIS & RHEUMATOLOGY CENTER

470 Birchwood Ave, Suite C • Bellingham, WA 98225

(360) 734-5754 Fax (360) 734-0586

www.bellinghamarthritis.com

Margaret Kinsella, MD **Naomi Sullivan, MD**

New Patient/Consultation Intake Referral

Patient Name: _____ **DOB:** _____ **Phone:** _____

Referring Provider: _____ **Referring Provider Phone:** _____

Previous Rheumatology Care (Y/N) _____ **If Y, Provider/Location** _____

Priority: ____ **Routine** ____ **High Priority** ___ **Urgent**
(If urgent, provider must call one of our doctors to briefly discuss. 360-318-6940 will bypass reception)

Inflammatory or Autoimmune process you are suspicious of (please circle all that apply):

RA PMR Lupus Raynaud's Scleroderma Gout Psoriatic Arthritis

Sjogrens Ankylosing Spondylitis Other _____

Symptoms suggestive of inflammatory or autoimmune process or specific question you'd like addressed?

_____

_____

_____

_____

Please describe any supportive exam findings:

_____

_____

_____

Is there anything else you'd like us to know?

_____

_____

Lab Values ____+ ANA _____ESR ____ RF _____CCP _____CRP _____ANCA _____Uric Acid

____ Other _____

Date: _____ **Physician Signature** _____