

TRIANGLE ARTHRITIS & RHEUMATOLOGY
ASSOCIATES

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PHYSICIAN REFERRAL FORM

Please fax completed form, current lab results as well as any X-ray reports and most recent notes to 919-881-2026.

PATIENT NAME: _____

DOB: _____

PATIENT PHONE _____

ALTERNATE PHONE _____

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

REASON FOR CONSULT _____

REFERRING PHYSICIAN _____

OFFICE CONTACT _____

OFFICE PHONE/FAX _____

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