*Referral is required for all new patients

Dedri Ivory, MD
River City Medical and Arthritis Center
3510 Pemberton Square Blvd, Vicksburg, MS 39180
Phone: 601-501-6991
Fax: 601-501-6987 (EHR)

RHEUMATOLOGY CONSULTATION REFERRAL FORM

Patient Name: _________________________ Patient DOB: ____________ Patient Phone# ___________________

Referring provider office must complete all 5 sections below
Call 601-501-6991 if no response within 5 days

- **Attach patient demographics, patient contact info, and insurance info to this form**
- **Attach medical records and insurance card (front & back copy)**
- **Complete REFERRING PROVIDER information below:**

Physician: ____

Address: ____

Phone #: ____

Fax #: ____

Contact Person: ____

Contact Phone: ____

- **Include ALL LABS and X-RAY reports <u>related to this referral</u> so that we don't duplicate testing**
- **Please indicate the specific reason for this referral below:**

[ ] Joint Pain	[ ] Arthritis	[ ] Positive ANA*	[ ] Lupus (SLE)
[ ] Fibromyalgia	[ ] Muscle Pain	[ ] Osteoarthritis	[ ] Abnormal Labs
[ ] Osteoporosis	[ ] Vasculitis	[ ] Rheumatoid Arthritis	[ ] Gout/Pseudogout
[ ] Raynaud's	[ ] Uveitis or iritis	[ ] Positive CCP/RA Factor*	
[ ] Sjögren's (dry eye/mouth)		[ ] Psoriasis or Psoriatic Arthritis	
[ ] Ankylosing Spondylitis		[ ] Inflammatory Arthritis 2nd to Inflammatory Bowel Disease	

[ ] Other: ____

Please fax completed referral to **601-501-6987**
Thank you for your referral!