Puget Sound Rheumatology

20700 Bond Rd NE, Building B, Suite 104
Poulsbo, WA 98370
Tel: 360.930.6314 | Fax: 360.626.1292
Email: PSR@psrheum.com
Web: www.psrheum.com

RHEUMATOLOGY REFERRAL CONSULTATION/TRANSFER OF CARE REQUEST

Patient's Name: Last _____ First _____ M. I. ____ Sex: M / F (circle one)

Date of Birth ____/_____/_____ Home # _____ Cell # _____ Work # _____

Home address _____ City _____ State ____ Zip_____

Primary Insurance Information

Insurance & Policyholder Name _____ Date of Birth ____/____/____

Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Secondary Insurance Information

Insurance & Policyholder Name _____ Date of Birth ____/____/____

Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Additional Information

Provider Name _____ Provider Phone _____

Reason for Consultation _____ Provider Fax _____

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Are there records available for release to PSR for consultation? ☐ Yes ☐ No (please check one)

Provider Signature _____ Date_____