Patient Referral Form

Indiana Rheumatology & Infusion Center

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Thank you for considering **Indiana Rheumatology & Infusion Center** for your patient's care. We are committed to providing **timely, compassionate, and expert rheumatologic care**, and we appreciate the opportunity to collaborate with you.

Referring Provider: _____ **Practice Name:** _____
Phone: _____ **Fax:** _____
Patient Name: _____ **Date of Birth:** _____
Patient Phone: _____ **Patient Email:** _____
Insurance: _____ **Secondary Insurance:** _____

Reason for Referral (check all that apply):
☐ Rheumatoid arthritis
☐ Psoriatic arthritis, other inflammatory arthritis
☐ Autoimmune/connective tissue disease (lupus, Sjögren's, scleroderma)
☐ Gout
☐ ANA (+), RF (+)
☐ Bone health optimization
☐ Infusion therapy needs
☐ Other: _____

Relevant Clinical Notes, Labs, Imaging Attached?
☐ **Yes** ☐ **No**

We look forward to collaborating with you.

Sincerely,

Carla F. Gamarra-Hilburn, MD

Indiana Rheumatology & Infusion Center

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