MICHIGAN RHEUMATOLOGY
& WELLNESS CENTER, PLC
Tel 248.923.1300 - Fax 248.218.1071 - Email info@mirwc.com
3950 South Rochester Road, Suite 1300- Rochester Hills, Michigan, 48307

Medical Records Request

Thank you for your recent patient referral. To ensure a comprehensive evaluation, we kindly request a copy of the patient's medical records, including chart notes; pharmacy; laboratory test results; radiology, ultrasound and surgical reports pertinent to the reason of referral. Please send the records via **fax to (248) 218-1071** or through **Direct Secure Messaging** before the patient's scheduled appointment.

Patient Information

NAME: _____

DOB: _____

APPOINTMENT DATE: _____

If you have any questions or concerns, you can reach us by calling our New Patient Coordinator at

248-509-5918 Tuesday to Friday from 4pm to 8pm.

Thank you,

Michigan Rheumatology and Wellness Center

MIRWC

REQUEST FOR CONSULTATION

Any records and labs relating to the patient's disease-state need to be sent or fax or via Direct Secure Messaging prior to appointment scheduling.

Date: _____

Patient information:

_____ _____ _____

Last Name First Middle Initial DOB Phone

_____ _____

Primary Insurance Company Member ID

_____ _____

Secondary Insurance Company Member ID

PLEASE SEND COPY OF FRONT AND BACK OF INSURANCE/S CARD/S

******FOR BLUE CARE NETWORK /HMO PATIENTS, PLEASE SEND THE GLOBAL REFERRAL ALONG WITH THIS FORM******

Referring Physician Information:

_____

Last Name First

_____ _____ _____

Address Telephone Fax

<u>Reason for Request for Consultation</u>.

_____

_____

_____

_____

Fax: 248.218.1071

Ph: 248.923.1300

3950 S ROCHESTER RD, STE 1300.
ROCHESTER HILLS,
MI 48307