Date: [Insert Date]

To: [Rheumatologist Name/Clinic Name]
Address: [Clinic Address]
Fax/Phone: [Clinic Contact Information]

From: [Referring Physician Name]
Practice Name: [Practice Name]
Address: [Practice Address]
Phone/Fax: [Practice Contact Information]

RE: Rheumatology Consultation Request

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance: [Insurance Provider & ID Number]

Reason for Referral: Diagnostic evaluation for suspected autoimmune/connective tissue disease.

Clinical Presentation:
[Briefly describe symptoms: e.g., joint pain, swelling, morning stiffness, photosensitive rash, fatigue, Raynaud's phenomenon]

Relevant Physical Exam Findings:
[List findings: e.g., synovitis of MCP joints, restricted ROM, malar rash]

Initial Laboratory/Diagnostic Results:

- ANA: [Result]
- RF/Anti-CCP: [Result]
- ESR/CRP: [Result]
- CBC/Metabolic Panel: [Result]
- Imaging: [Relevant X-ray or Ultrasound findings]

Current Medications:
[List medications, especially NSAIDs or Prednisone]

Urgency: [Routine / Urgent]

Please evaluate this patient for a formal diagnosis and management recommendations. All relevant clinical notes and lab reports are attached to this request.

Thank you for your expertise and for participating in this patient's care.

Sincerely,

[Referring Physician Signature]
[Referring Physician Printed Name]
[NPI Number]