ARTHRITIS CONSULTANTS OF TIDEWATER

APPOINTMENT REQUEST

FAX: 757-491-9359	Phone: 757-491-7359

We appreciate your business. Thank you for your referral!

DATE: _____

☐ **STANDARD REQUEST**
☐ **URGENT REQUEST**
WHY: _____

REFERRING PHYSICIAN: _____ Point of Contact_____

Phone #: _____

DIAGNOSIS:_____ Fax #: _____

SCHEDULE:

☐ DEXA Scan ☐ Infusion ☐ Musculoskeletal Ultrasound

☐ Consult, I want the patient to see:

☐ FIRST AVAILABLE (fastest turnaround time)

☐ Tatiana Keck, M.D. F.A.C.R. ☐ Janice Sherwood, M.D. F.A.C.R.

☐ Gary Siegel, M.D. F.A.C.R. ☐ Michael Cannon, M.D. F.A.C.R.

PATIENT DEMOGRAPHICS:

Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Address: _____

Insurance Plan: _____ ID #_____

To start the processing of your referral, **ALL** the following support documents must **FIRST** be received:

- Demographic/contact information
- Current medication list
- Last 3 chart notes
- Insurance Card/s (Front and Back)
- Official Referral from Insurance Company (if required)
- Last 3 chart notes
- Recent labs
- Radiological Reports e.g., X-Ray/MRI/DXA (If Applicable)

Appointment Information:

Date: _____

Time: _____

Doctor: _____

Office Location:

☐ **Virginia Beach**
☐ **Chesapeake**
☐ **Cape Charles (ES)**

933 First Colonial Rd Suite 100, Virginia Beach, VA 23454
680 C Kingsborough Square, Chesapeake, VA 23320
216 Mason Ave, Cape Charles, VA 23310