We have scheduled the appointment with Dr. _____ on _____/_____/_____.

Denver Arthritis Clinic

CONSULT REQUEST ORDER

200 Spruce Street #100, Denver, CO 80230
Phone: 303-394-2828 *Fax:* 303-320-0242

Meridian Location:
9570 S. Kingston Ct #220, Englewood, CO 80112
Phone: 303-762-6300 *Fax:* 303-703-0169

FAX:

Kenneth Glassman, M.D.
Michael Charney, M.D.
Vance Bray, M.D.
Mark Malyak, M.D.
Timothy Gensler, M.D.
Kathryn Hobbs, M.D.
Ryan Antolini, M.D.
Annemarie Whiddon, M.D.
Stephen Murphy, M.D.
Ndudi Oparaeche, M.D.
Kim Nguyen Tyler, M.D.
Michelle Kenrick, RN, FNP

You have requested a consultation for:

Patient Name _____ Today's Date _____

DOB _____

Referring Provider _____ PCP _____

Patient is to return to Referring / PCP for Follow-Up YES / NO

PROCEDURE REQUESTED *(check appropriate box)*

☐ Consult Only

☐ Consult and Treat

INDICATIONS / REASONS

Provider Signature: **Date**

Provider Phone:

A written report will be sent on all consults.

ATTN: MEDICAL RECORDS

After consult above is sign by physician, please fax this form along with the following information to us at **Lowry: 303-320-0242 or Meridian: 303-703-0169**.

- Recent lab work
- X ray reports
- Recent office notes
- Copy of insurance card – front and back
- Insurance Referral: if needed (please include labs & x-rays)