



RHEUMATOLOGY REFERRAL For Abigail Turnbough, DO

Referring provider _____

Fax number: _____ Phone number: _____

Thank you for referring:

Patient Name _____

DOB _____

Before we can schedule your patient we require the following additional information.

___ Recent Clinic Notes

___ Reason for Rheumatology Consultation _____

___ Lab Results * indicate if none ___

___ X-Ray Reports * indicate if none ___

___ Demographic Information Sheet

Upon receipt and review of this information, we will contact your patient to schedule an appointment with the next available date.

Please fax the requested information to 307-675-4475

Thank you for your referral.

Dr. Abigail Turnbough
Rheumatology
Sheridan Memorial Hospital
307-675-4474