



**RHEUMATOLOGY REFERRAL**  
**For Abigail Turnbough, DO, FACR**

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