

Referring Physician:

Tel: _____

Fax: _____

Beeper: _____

**Yale Medical Group
Consultation Record**

To: Yale Rheumatology
DANA Clinic
800 Howard Ave
New Haven, CT 06510
Tel: 203 737 5430
Fax: 203 785 7053

Patient Unit Number:

Name:

DOB:

Address:

Current phone number:

Type of Service Requested

Consultation only

Consult and treat

Procedure

Nature of Clinical Problem:

Diagnoses/PMH/PSH:

Current Medications:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

The referral will not be processed unless the following are attached:

- * Relevant laboratory work & reports of imaging studies
- * Discharge or equivalent summary
- * Pertinent medical records

Please Fax this form with the necessary documents to Annette Ayala: Fax (203) 785 7053