



Medical Clinic of North Texas  
RHEUMATOLOGY

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# Rheumatology

Consultation     Referral

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Rheumatology

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## GENERAL INFORMATION

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Allergies: \_\_\_\_\_

Sex:     Male     Female

### FROM THE OFFICE OF:

Physician Name: \_\_\_\_\_

Practice Name/Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

State Lic. #: \_\_\_\_\_ DEA #: \_\_\_\_\_

NPI #: \_\_\_\_\_

Nurse/Key Office Contact: \_\_\_\_\_

## STATEMENT OF MEDICAL NECESSITY

### Primary Diagnosis:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Rheumatoid Arthritis (714.0)   | <input type="checkbox"/> Lupus (710.0)          | <input type="checkbox"/> Polymyositis (710.4) |
| <input type="checkbox"/> Ankylosing Spondylitis (720.0) | <input type="checkbox"/> Osteoporosis (733.09)  | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Psoriatic Arthritis (696.0)    | <input type="checkbox"/> Osteoarthritis (715.0) |   |

Please Attach a Copy of the Patient's Insurance Card, Pertinent/Last Visit Note, Labs and Imaging Studies.