Pine Hollow Partners, LLC
6200 Pine Hollow Dr Suite 400
East Lansing, MI 48823
PH: 517-339-1676
Fax: 517-339-2716

Iris Zink, MSN, ANP-BC, APRN
Christopher Title,MSN, FNP-BC, APRN
Claudia Rivera-Salas, DNP,APRN, NP-C
Katherine Bursma, MSN, FNP-BC, APRN

Pine Hollow Partners

Patient Triage Sheet

Providers: Iris Zink ANP-BC, MSN, RN-BSN, Christopher Title FNP, MSN, RN-BSN,
Claudia Rivera-Salas DNP, MSN, BSN, Katherine Bursma FNP, MSN, RN

Please check all boxes that apply to your patient:

- Psoriasis/Rash: Suspect autoimmune
- +RF/ +CCP: Suspect Rheumatoid Arthritis
- +ANA > 1:320 titer suspect or confirmed Lupus/Sjögrens/Scleroderma
- Previously diagnosed autoimmune disease/assume care/second opinion
- Lower extremity joint pain that started within 6 months of infection especially after chlamydia, gonorrhea, or food borne illness
- Gout: Uric Acid >6.0
- Hidradenitis suppurativa: painful groin or axillary lesions
- Osteoarthritis knee for injection evaluation
- Osteoporosis
- Fibromyalgia
- Back Pain that awakens the patient at night multiple times: Suspect Ankylosing Spondylitis, Psoriatic Arthritis, Crohn's Disease or Ulcerative Colitis
- Plantar Fasciitis, Achilles Tendon inflammation, bursitis, joint pain or SI pain
- Muscle Weakness: Suspect dermatomyositis or polymyositis
- Polymyalgia Rheumatica
- Elevated CRP or Sed Rate

- **As we are Nurse Practitioners, we do not prescribe NARCOTICS. It is our goal to treat the underlying cause of autoimmune disease with targeted biologic medications**
- **Chronic spinal pain from known OA may be best managed by a pain clinic**
- **Hepatitis C patients must be evaluated and treated BEFORE we treat with any immunomodulating medications**
- **Please call with any and all referral questions**
- **We have Spanish speaking providers available.**

****ATTENTION**** **Please include with your referral: Patient Demo Sheet, any office notes that pertain to why the patient is being seen, any labs and images that we may need. Also if a patient has BCN include the prior auth to be seen in our office.**

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Consultation Request Form

Patient Name:_____ DOB: _____ Gender:_____

Address:_____

Primary Phone:_____Alternate Phone:_____

Primary Insurance:_____ Secondary Insurance:_____

PCP:_____

Reason for Referral:

_____

_____

_____

_____

Other pertinent information:

_____

_____

_____

_____

Referring Physician: _____ NPI: _____

Address: _____

Phone Number: _____ Fax Number: _____

Thank you for choosing Pine Hollow Partners