

**REFERRAL FORM**

Date: \_\_\_\_\_ Form completed by: \_\_\_\_\_

Location (check one):  Grayling  Lansing  Saginaw  Traverse City

Requested Department \_\_\_\_\_

New patient  Updated patient information (if updated information please fill out name, date and date of birth only unless changes have occurred)

Patient name \_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_  
DOB (Date of birth) \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_ Alt. Phone \_\_\_\_\_

Diagnosis \_\_\_\_\_

Reason for referral \_\_\_\_\_

Provider Requested (if known): \_\_\_\_\_

Timeframe?  Urgent / Next Available  Routine

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_ Email \_\_\_\_\_

**INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following):**

Primary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_

Insurance company name \_\_\_\_\_

ID/Policy # \_\_\_\_\_ Group \_\_\_\_\_ Phone \_\_\_\_\_

Employer name \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_

Insurance company name \_\_\_\_\_

ID/Policy # \_\_\_\_\_ Group \_\_\_\_\_ Phone \_\_\_\_\_

**Please fax referral form and the following prior to patient appointment at (313) 916-5717:**

Pertinent biopsy reports  Pertinent consult notes  Pertinent lab reports  Pertinent imaging reports (CT, MRI, X-ray)