Specialty Referral Form

Phone: (269) 337-6289 Fax: (269) 337-6547

***** Please include a current History and Physical, any office notes, lab and/or radiology results, growth charts, current medications, problems list, SMOKING HISTORY, and/or treatments attempted, that pertain to this consult request.*****

Specialty and/or physician to evaluate patient: ______________________ Today's Date: __________

Reason for request (Diagnosis): ______________________________

INDICATE URGENCY:

☐ Urgent
☐ Routine

IS THIS RELATED TO:

☐ Workers' Comp
☐ Auto
☐ Neither

Patient Name: ______________________ Patient DOB: __________

Patient's Social Security #: ______________ ☐ Male ☐ Female

Patient's Address: ______________________________
Street City State Zip

Primary Phone #: ______________ Secondary Phone #: ______________

Parent/Guardian (if pt is under 18 years old): ______________ Parent/Guardian DOB: __________

Does the patient require an interpreter? ☐ Yes ☐ No If yes, what type/language? ______________

Primary Insurance: ______________ Secondary Insurance: ______________

Group #: ________ Policy #: ________ Group #: ________ Policy #: ________

Policy Holder (*PH*): ______________ Policy Holder (*PH*): ______________

PH SS#: ________ PH DOB: ________ PH SS#: ________ PH DOB: ________

****** Please include a LEGIBLE copy of the insurance ID card, front and back ******

Referring Physician: ______________________ MD/DO

Physician's Full Address: ______________________________

Office Phone #: ______________ Office Fax #: ______________

Contact Person: ____________ Department: ____________ Phone/Extension: ____________

Primary Care Physician: ____________ PCP Phone: ____________ PCP Fax: ____________

This request was received by Referrals Dept. on: ____________ by ____________ Please allow ______ days to process.

Form Revised 07/14/11