McLaren
BAY REGION

McLaren Bay Pulmonology and Critical Care
714 S. Trumbull, Suite 200, Bay City, MI 48708
Phone: (989) 316-4010 Fax: (810) 600-7694

Referral Form

Patient Name **Last:** _____ **First:** _____

Gender: **Male** ☐ **Female** ☐ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell:** _____

Referring Provider: _____ **Office Contact:** _____

Phone: _____ **Fax:** _____

INSURANCE – Send Copy of Insurance Card OR Demographic Page

Is Authorization Needed? **No** ☐ **Yes** ☐

Authorization Number: _____ **Effective Dates:** _____ **to** _____

Reason for Referral: _____

Provider Preference: **Kamalpreet Dhaliwal, MD** ☐ **Hira Iftikhar, MD** ☐ **First Available** ☐

SEND ALL RECORDS AND DIAGNOSTIC TESTING PERTAINING TO REASON FOR REFERRAL

Patient will need a Pulmonary Function Test prior to appointment for the following:

Shortness of Breath, Cough, Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, Restrictive Lung Disease, Pulmonary Fibrosis, Interstitial Lung Disease, Surgical Clearance

Comments: _____

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