MCLAREN MULTI-SPECIALTY CLINIC
OB/GYN REFERRAL/CONSULTATION FORM

2727 S. PENNSYLVANIA AVE
LANSING, MI 48910
(517) 975-3750 FAX (517) 975-3755

PRIORITY: ☐ Routine ☐ Urgent Needs to seen within_____ days.

☐**CONSULTATION-**EVALUATE AND ADVISE ☐**REFERRAL-**ASSUME TOTAL MANAGEMENT FOR THIS KNOWN PROBLEM

REASON FOR CONSULTATION/REFERRAL

INDICATE ANY TESTING PATIENT HAS HAD FOR THIS CHIEF COMPLAINT-PLEASE SEND REPORT COPIES WITH THIS REQUEST:

○ LABS ○ XRAY ○ULTRASOUND ○RECENT PROGRESS NOTE ○NONE ○ OTHER

PATIENT INFORMATION

PATIENT NAME: D.O.B.

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: WK : CELL:

SSN: TYPE OF INSURANCE (PLEASE SEND COPIES OF INSURANCE CARD(S):
AUTHORIZATION NUMBER-SEND COPY OF AUTH FORM:

REQUESTING PHYSICIAN /GROUP

PHYSICIAN NAME: CONTACT PERSON:

OFFICE # OFFICE FAX #:

OFFICE ADDRESS: CITY: STATE: ZIP:

CONSULTING / REFERRAL PHYSICIAN OFFICE USE ONLY

APPOINTMENT: ______________________ ON_______________________@__________________
PROVIDER DATE TIME

PACKET SENT ON: REFERRING OFFICE NOTIFIED: PT.NOTIFIED: FORM FAXED:

BY: BY: BY: BY:

WE WILL BE SENDING THE PATIENT AN INFORMATION PACKET WHICH WILL INCLUDE DIRECTIONS TO OUR FACILITY AND DATE/TIME OF THEIR APPT. IF YOU HAVE ANY QUESTIONS OR INFORMATION PLEASE CONTACT OUR OFFICE. THANK YOU FOR THE REFFERRAL!

THE INGHAM REGIONAL MULTI-SPECIALTY CLINIC ALSO INCLUDES FAMILY MEDICINE, INTERNAL MEDICINE, GENERAL SURGERY AND ORTHOPEDICS.