MCLAREN MULTI-SPECIALTY CLINIC
OMT REFERRAL FORM
2727 S. PENNSYLVANIA AVE, LANSING, MI 48910
PHONE (517)975-3750 FAX (517) 975-3755

PLEASE PRINT/MUST COMPLETE ENTIRE FORM:

PATIENT NAME:________________________________D.O.B.________________________

GUARDIAN'S NAME IF MINOR:____

FULL ADDRESS:____

CITY:___________________, MI ZIP:__________________PHONE #_________________

INSURANCE*:* ***PLEASE BE SURE TO ANY NECESSARY INSURANCE AUTHORIZATION.***
***** MUST INCLUDE COPY OF INSURANCE/ ID CARD(S)*****

PATIENT
INSURANCE:____
DIAGNOSIS:____

*** THE RESIDENT CLINIC DOES NOT SEE WORK COMP/AUTO RELATED INJURIES***

HAS PATIENT HAD SURGERY FROM THIS CONDITION? YES NO
*****IF SO, PLEASE INCLUDE SURGEON'S NAME AND OPERATIVE REPORT*****

PLEASE INCLUDE ANY RADIOLOGY REPORTS AND H&P NOTES WITH THIS REFERRAL.

HAS PATIENT BEEN PREVIOUSLY SEEN AT THIS CLINIC?______IF SO, WHEN_____________

REFERRING FACILITY:__________________________DR.__________________________
ADDRESS:___________________________CITY:____________________ ZIP_____________
CONTACT PERSON:____
PHONE #______________________________FAX #___________________________________

WE WILL CONTACT PATIENT WITH APPT/DATE/TIME.
OUR OFFICE WILL SEND YOU A FAX OF THE CONFIRMED APPT.

APPOINTMENT SCHEDULED:______________________TIME:_______________

THANK YOU FOR THE YOUR REFERRAL

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FOR RESIDENT USE ONLY:
PATIENT MUST BE SEEN WITHIN: URGENT 1 WEEK 2 WEEKS 3 WEEKS 1 MONTH

RESIDENT SIGNATURE:________________________________ DATE____________________