



Practice Management
CONSULTATION/REFERRAL FAX FORM
McLaren Greater Lansing Women's Health Locations:

<input type="checkbox"/> 12805 Escanaba Dr., Ste. 2 DeWitt, MI 48820 (517) 975-9750 Fax: (517) 975-9777 Theresa May-Hartle, DO Upendra Shah, MD	<input type="checkbox"/> 2104 Jolly Rd., Ste. 220 Okemos, MI 48864 (517) 975-1400 Fax: (517) 975-1405 Sandra Russell, DO Elizabeth Lindsey, DO Laura Kota, DO Elizabeth Root, CNP	<input type="checkbox"/> 1035 Charlevoix Dr., Ste. 200 Grand Ledge, MI 48837 (517) 626-3100 Fax: (517) 626-3110 Elizabeth Ferik, DO Betty Dawson, CNP	<input type="checkbox"/> 101 E. Spicerville Hwy. Eaton Rapids, MI 48827 (517) 233-0170 Fax: (517) 663-2512 Sandra Russell DO Elizabeth Root, CNP
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PRIORITY: ☐ Routine ☐ Urgent - Needs to be seen within _____ days.

INTENT OF REQUESTING PHYSICIAN / GROUP - REQUESTING PHYSICIAN OFFICE MUST CHECK ONE

☐ 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 REQUEST:

☐ LABS ☐ X-RAY ☐ ULTRASOUND ☐ RECENT PROGRESS NOTE ☐ NONE ☐ OTHER:

PATIENT INFORMATION

PATIENT NAME:		DATE OF BIRTH:		SOCIAL SECURITY NO.:	
ADDRESS:		CITY:		STATE:	ZIP:
HOME PHONE:		WORK PHONE:		CELL PHONE:	
TYPE OF INSURANCE (PLEASE SEND COPIES OF INSURANCE CARD[S]):					
AUTHORIZATION NUMBER (PLEASE SEND COPY OF AUTHORIZATION FORM):					

REQUESTING PHYSICIAN / GROUP

PHYSICIAN NAME:	CONTACT PERSON:		
OFFICE NUMBER:	OFFICE FAX:		
OFFICE ADDRESS:	CITY:	STATE:	ZIP:

CONSULTING / REFERRING PHYSICIAN OFFICE USE ONLY

APPOINTMENT WITH: _____ ON _____ @ _____			
PROVIDER DATE TIME			
PACKET SENT ON:	REFERRING OFFICE NOTIFIED:	PATIENT NOTIFIED:	FORM FAXED:
BY:	BY:	BY:	BY:

WE WILL BE SENDING THE PATIENT AN INFORMATION PACKET WHICH WILL INCLUDE DIRECTIONS TO OUR FACILITY AND THE DATE AND TIME OF THEIR APPOINTMENT. IF YOU HAVE ANY ADDITIONAL QUESTIONS OR INFORMATION, PLEASE CONTACT OUR OFFICE.

THANK YOU FOR ALLOWING US TO PARTICIPATE IN THE CARE OF YOUR PATIENT.