Cardiology - Fax: (517) 347-8393
Cardiothoracic and Vascular - Fax: (517) 483-4861
Cardio/Pulm Testing - Fax (517) 975-2695
Cardiac Rehabilitation - Fax: (517) 975-7062
Diabetes Education - Fax (517) 975-2200
Family Medicine Resident Clinic - Fax: (517) 975-3755
General Surgery - Fax: (517) 913-4011 or (517) 487-2059
Multispecialty Clinic - Fax: (517) 975-8925
Pain Management Center - Fax: (517) 975-6630
Radiation Oncology - Fax: (517) 975-7810
Rehabilitation Services - Fax: (517) 975-3520
Respiratory - Fax (517) 975-6660
Sleep Center - Fax: (517) 975-3390
Vascular Lab - Fax: (517) 975-9405
Wound Care and Hyperbaric Center - Fax: (517) 975-1514

McLaren
GREATER LANSING

PLEASE COMPLETE AND FAX WITH MEDICAL RECORDS

Specialty Service Referral Form

Referring Physician:_____ Phone: _____ Fax: _____

Patient Name:_____ Date of Birth: _____

Patient Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Request for: ☐ Consult ☐ Referral ☐ Consult and Treat ☐ Procedure

Appointment Priority: ☐ ASAP ☐ Routine (1-2 weeks) ☐ Other _____

Reason for Referral/Diagnosis: _____

Insurance Type: ☐ BC/BS ☐ Medicare ☐ BCN ☐ Medicaid ☐ PHP ☐ Aetna

McLaren (Advantage / Medicaid) OTHER _____

Contract #: _____Group #: _____ Copay $_____

Subscriber Name: _____DOB: _____ Relationship to Patient:_____

Appointment Confirmation:

Appointment Date: _____ Time:_____

Scheduled with Dr. _____

PLEASE FAX WITH COPIES OF MEDICAL RECORDS,
TESTING, X-RAY / MRI / CT SCANS, AND NECESSARY REPORTS.
****THIS INFORMATION MUST BE RECEIVED PRIOR TO APPOINTMENT BEING SCHEDULED****