

McLaren Bay Pulmonology and Critical Care
3175 W Professional Dr. St. 2
Bay City, MI 48706
Ph: 989 316-4010 F: 810 600-7694

Referral Form

Patient Name Last: _____ First: _____

Gender: Male _____ Female _____ DOB: _____

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: Dr Kwon ____ Dr Iftikhar ____ 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: _____
