McLaren
GREATER LANSING

COMPREHENSIVE BREAST SERVICES CLINIC REFERRAL FORM

_____ first available ____ Suzanne M. Hanses D.O. /_____ Troy Ferguson D.O.
Sarah Barber, RN, Breast Cancer Nurse Navigator

McLaren Greater Lansing Comprehensive Breast Services Clinic
3520 Forest Road, Lansing, MI 48910
Phone: (517) 975-6425 Fax: (517) 975-6423

Patient Name:_____DOB:_____

Address: _____City: _____State____Zip:_____

Home Phone:_____Work #:_____Cell #:_____

Diagnosis/Reason for Referral:_____

Location and dates of recent breast imaging:_____
(If imaging was performed anywhere other than McLaren, patient must bring imaging prior to clinic appt. Imaging includes mammograms, breast ultrasound, breast MRI.)
***Please fax this form, treatment history, insurance cards, pathology and radiology reports.**
Has patient been seen by at McLaren Comprehensive Breast Clinic before? Y or N If yes, when_____

REFERRING PHYSICIAN INFORMATION

Referring Physician:_____Contact Person:_____
Office Phone:_____Office Fax:_____
Patients Primary Care Physician:_____
PCP Phone #:_____PCP Fax:_____

Appointment Date:_____Time:_____
Pt. notified: Y or N Referring Physician Notified: via fax or phone on _____
New patient packet given to patient or mailed to patient on: _____