



BAY REGION

### McLaren Bay Orthopedic Surgery – REFERRAL FORM

4 Columbus Ave, Suite 160, Bay City, MI 48708 | 2110 M-76, Suite 9, West Branch, MI 48661  
Phone: 989-393-2777 | Fax: 989-894-6181

Referring Office: Please complete entire form and **FAX to 989-894-6181**. Thank you!

**PHYSICIAN PREFERENCE:**  Dr. D'John (Bay City)  Dr. Lewis  First Available  
 Dr. D'John (West Branch)  Dr. Render

Today's Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Gender: Male  Female  Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

**Is this a result of:** Injury?  Yes  No Car Accident?  Yes  No Work Accident?  Yes  No

Other Accident? Please describe: \_\_\_\_\_

Date of Injury or Onset of: \_\_\_\_\_ (Month/Day/Year required)

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Patient ID #: \_\_\_\_\_ Group#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Patient ID #: \_\_\_\_\_ Group#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Please FAX this form back to us with labs, tests, notes, **including other physician's notes, records, and any information pertaining to this referral**. Please include all insurance information and prior authorization that may be required. We will review all information prior to contacting the patient with a scheduled appointment.

1. Does patient's insurance require a referral and/or authorization?  Yes  No

Referral number and/or copy of referral: \_\_\_\_\_

2. Referring office to check tests completed and FAX results:

X-ray  Bone Scan  MRI  MRA  EMG/NCS  CT  Surgery Other: \_\_\_\_\_

#### BAY REGION ORTHOPEDIC USE ONLY

#### REFERRAL USE ONLY

Appointment: Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Notification: Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Time: \_\_\_\_\_

Referring Provider Notified: Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Time: \_\_\_\_\_

New Packet Mailed On: Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Time: \_\_\_\_\_

Insurance Verified:  Yes  No Initials: \_\_\_\_\_ Time: \_\_\_\_\_