McLaren
BAY REGION

McLaren Bay Orthopedic Surgery
REFERRAL FORM

Phone: 989-393-2777
Fax: 989-894-6181

4 Columbus Ave, Suite 160, Bay City, MI 48708
3190 E. Midland Rd, Bay City, MI 48706
2110 M-76, Suite 9, West Branch, MI 48661

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

Patient will be offered either Bay City location based on need.

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

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: _____

REFERRAL USE ONLY