



BAY REGION

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## McLaren Bay Physical Medicine & Rehabilitation Referral Form

To schedule a new patient appointment, please complete this form and fax to our office with the following information:

- Current Insurance Card(s)
- Auto or Work Comp. Open & Billable Letter
- Office Notes
- Diagnostic Imaging Reports

*When the referred patient is scheduled, we will inform your office of the date and time.  
 The patient will be scheduled one time. If the patient cancels or no shows for their appointment, it will be their responsibility to reschedule the missed appointment.  
 Thank you for the opportunity to participate in the care of your patient.*

### PATIENT INFORMATION

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

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

### INSURANCE – Include Legible Copy of Insurance Card Front & Back

#### PRIMARY INSURANCE

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

Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

#### SECONDARY INSURANCE

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

Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

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

### OFFICE USE ONLY

Preferred Office Location:  Bay City OR  West Branch

Type of Appointment Requested:  Evaluation  EMG-Upper  EMG-Lower

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM Location: \_\_\_\_\_