

McLaren Print System Order

Order No: 44507
Order Date: 2019-04-15
User: TINA PLAUTZ
Phone: 248-674-2259

Ship Location: MCLREN OAKLAND WATERFORD MEDICAL ASSOCIATES
5210 Highland Rd, Suite 201
WATERFORD, MI 48327

Forms

Quantity: 500
Paragon Dept No: 73000
Dept Name: Waterford Medical Associates
Company Number: 810

Order Total Price: 0.00

Item Number: MM-34330
Item Description: Referral / Consultation Request
Revision Date: 11/17/2011
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info:

McLaren Medical Group
REFERRAL/CONSULTATION REQUEST

To: Dr. _____ Specialty _____

Referred to you from provider _____

Patient Name _____ DOB _____ Phone (____) _____

Date of Referral _____ Patient needs appointment with you within _____ days/weeks

Insurance Type _____

Diagnosis _____

Reason for Referral _____

History/diagnostic testing completed/therapeutic measures tried _____

See attached patient registry report See attached e-prescription list

See attached test results No test results available

Request for: Office Visit Type Appointment time preference

<input type="checkbox"/> Initial consultation	<input type="checkbox"/> Evaluate	<input type="checkbox"/> A.M.
<input type="checkbox"/> Follow-up	<input type="checkbox"/> Evaluate/Treat	<input type="checkbox"/> P.M.
<input type="checkbox"/> Pre-Certification	<input type="checkbox"/> Other _____	<input type="checkbox"/> None

Signature of referring provider (if applicable) _____ Date _____

Appointment Date/Time _____ *** Please notify us immediately if our patient does not keep their appointment

Comments _____

PLEASE OBSERVE THE FOLLOWING GUIDELINES:

- Please use McLaren facilities for all tests, treatments, and procedures.
- Contact the Primary Care Physician if further visit/testing is needed before the appointment is made.
- Use Network Formulary when prescribing medications.
- Send consultation report and any applicable test results to Primary Care Physician within seven (7) days of service.

Spec Info:

Office Use Only
Date follow up letter received from Specialist _____
Reason patient did not keep appointment _____
Date patient-completed Specialist evaluation _____

REFERRAL/CONSULTATION REQUEST