McLaren Business Products

McLaren Print System Order

Order No: 46414 Reprint Previous Order No: 5560
Order Date: 2019-06-21
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**
☐ Initial consultation ☐ Evaluate ☐ A.M.
☐ Follow-up ☐ Evaluate/Treat ☐ P.M.
☐ Pre-Certification ☐ Other ______ ☐ 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 visits/testing is needed before the appointment is made.
- Use Network Formulary when prescribing medicines.
- Send consultation report and any applicable test results to Primary Care Physician within seven (7) days of service.

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

Patient Name
Date of Birth

REFERRAL/CONSULTATION REQUEST