Joseph I. Shawi, M.D., FACOG
McLaren Health Pavilion
3175 W. Professional Drive
Bay City, MI 48706
Phone: (989) 316-4130
Fax: (989) 316-4135

McLaren
BAY REGION

Referral Date: _____

Patient Appt. Date:_____ Time: _____

The patient was contacted on _____ and notified of their appointment by _____
Date/Time Staff Initials

Please check the appropriate box:

☐ Requesting consultation for an opinion/recommendation.

☐ Other: _____

Referring Diagnosis: _____

Referring Physician: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax #:_____

******PATIENT INFORMATION (must be completed thoroughly)*****

Name: _____ DOB: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Work #:_____

Name of Guardian (if applicable):_____

Address:_____ City: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

Is this patient able to ambulate on their own? ☐ Yes ☐ No

If this patient uses a wheelchair, is this patient able to transfer from the wheelchair to an exam table without assistance? ☐ Yes ☐ No

*****INSURANCE INFORMATION (must be completed thoroughly)*****

Subscriber's Name: _____ Relationship to Patient:_____

DOB: _____Name of Insurance: _____

Policy #: _____ Group #: _____

PLEASE FAX ALL PERTINENT PATIENT RECORDS ALONG WITH THIS COMPLETED FORM. UPON RECEIVING THIS INFORMATION, YOUR OFFICE WILL BE CONTACTED WITH AN APPOINTMENT.

IMPORTANT! IF AN URGENT APPOINTMENT IS NEEDED, THE REFERRING PROVIDER IS ASKED TO CONTACT THE OFFICE AND SPEAK DIRECTLY TO DR. SHAWI.