Multi Specialty Ortho Clinic
Gratiot Medical Building
36500 Gratiot Ave, Suite 102
Clinton Township, MI 48035
Tel:(586) 790-9003
Fax:(586)-493-3606

REFERRAL/CONSULTATION REQUEST

Referring Physician: ____

Patient Name: ________________________________DOB: _____________Phone: (______)__________________

Insurance: ____

Diagnosis: ____

Reason for Referral: ____

History/diagnostic testing completed/therapeutic measures tried: ____

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Imaging must be completed prior to the patient's appointment and actual films/MRI CD must be brought to the appointment for the Ortho Physician to review.

Request for: **Office Visit Type**

- ☐ Initial consultation
- ☐ Evaluate/Treat

Signature of referring provider (if applicable):__________________________________Date:______________

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

Comments:____

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Office Use Only:

Date follow up letter received from Specialist:____________________

Reason patient did not keep appointment:________________________

Date patient completed Specialist evaluation:______________________

MO-155 (5.19)