McLaren Macomb
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

☐ Initial consultation
☐ Follow-up
☐ Pre-Certification
☐ Evaluate
☐ Evaluate/Treat
☐ Other _____

Appointment time preference

☐ A.M.
☐ P.M.
☐ 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: _____

White Copy: Patient
Canary Copy: Chart
Pink Copy: Tracking File

REFERRAL/CONSULTATION REQUEST
MO-34330 (1.20)

Patient Name:

Date of Birth: