McLaren Medical Group
Physical Medicine & Rehabilitation Referral Request

Primary Care Physician (PCP): ______________________________

Patient Name:______________________ DOB: __________ Phone: (   ) ______________

Insurance Type: ______________________________

Diagnosis: ______________________________ ____Is this related to work injury MVA

History/diagnostic testing completed/therapeutic measures tried: ______________________________

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Please send copies of all previous tests, consults, radiology reports, that have been done for this diagnosis.

Request for:

☐ Consult and treat (____ number of visits)

☐ Consult and treat, Women's musculoskeletal – Pregnancy related

☐ Consult and treat, Women's musculoskeletal – Pelvic floor dysfunction and/or pain

☐ NCV/EMG without consultation (interpretation and diagnosis only)

☐ NCV/EMG with consultation (interpretation with recommendations ☐ with follow-up care without follow-up)

Appointment time preference * **Please tell patient to arrive 15 – 30 minutes early for initial visit**

☐ AM ☐ PM ☐ None Appointment Date: ______________________________

Signature of PCP/referring physician: ______________________________ Date: ____________

For **HMO** insurances a) number of visits approved _______

b) start/end dates of referral – start: ____________ end: ____________

c) authorization number: ______________________________

Comments: ______________________________

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PLEASE OBSERVE THE FOLLOWING GUIDELINES:

- CONTACT THE Primary Care Physician if further visits/testing are needed before the appointment is made.
- Use Network Formulary when prescribing medication
- Send consultation report and any applicable test results to Primary Care Physician within seven (7) days of services.

Physical Medicine & Rehabilitation
Referral Request

MM-53 (11/13)

PATIENT NAME:

DATE OF BIRTH: