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: ______________________________

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☐ 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: ______________________________

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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:

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MM-34330 (11/17/11)