McLaren Business Products

McLaren Print System Order

Order No: 75016 Reprint Previous Order No: 75015
Order Date: 2023-02-01
User: Graphics Dept
Phone: 810-342-1066

Ship Location: **McLaren Port Huron**
1221 Pine Grove Attn: Nicole Pauly
Port Hiuron, MI 48060
Forms
Quantity: 1000
Paragon Dept No: 21600
Dept Name: MPH ER
Company Number: 210

Order Total Price: 43.50

Item Number: B-140
Item Description: Referral Form Bay Orthopedic Surgery
Revision Date: 01/23
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: Padded (25 Sheets Per Pad)
Drill: 3 Hole Top
Misc Info: 8.5x11 black

BAY REGION
ORTHOPEDIC SURGERY

PHYSICIAN REFERENCE
DR. RENDER DR. O'JOHN

Today's Date: ______
Patient Name: ______ D.O.B.: ______
Address: ______ City: ______ State: ______ Zip Code: ______
Home Phone: ______ Cell/Work: ______ Email Address: ______
Referring Physician: ______ Phone: ______ FAX: ______
Reason for Referral: ______
Is this a result of: Injury? ☐ Yes ☐ No | Date of Injury or Onset of: ______ (Month / Day / Year required)
Car Accident? ☐ Yes ☐ No
Work Accident? ☐ Yes ☐ No
Other Accident? ______
Family Physician? ______ Phone: ______ FAX: ______
Primary Insurance: ______ Subscriber: ______ D.O.B.: ______
Patient ID#: ______ GRP#: ______ Effective Date: ______
Secondary Insurance: ______ Subscriber: ______ D.O.B.: ______
Patient ID#: ______ GRP#: ______ Effective Date: ______

Please FAX this form back to us with labs, tests, notes, including other physician's notes, records, and any information pertaining to this referral. Please include all insurance information and prior authorization that may be required. We will review all information prior to contacting the patient with a scheduled appointment.

1. **Does patient's insurance require a referral and/or authorization? YES / NO**
   Referral number and/or copy of referral: ______
2. **Referring office to circle tests completed and FAX results:**
   X-ray; Bone Scan; MRI; MRA; EMG/NCS; CT; Surgery; Other: ______

BAY REGION ORTHOPEDIC USE ONLY	**REFERRAL USE ONLY**
Appointment Date: ______ Time: ______	
Patient Notification: Date: ______ Initials: ______ Time: ______	
Referring Provider Notified Date: ______ Initials: ______ Time: ______	
New Patient packet mailed on: Date: ______ Initials: ______ Time: ______	
Insurance Verified: Yes ______ No ______ Initials: ______ Time: ______	