McLaren Business Products

McLaren Print System Order

Order No: 82644
Order Date: 2024-01-26
User: Angie Claerhout
Phone: 9896673420

Ship Location: Bay Orthopedic Surgery
4 Columbus Ave Suite #160
Bay City, Michigan 48708
Forms
Quantity: 500
Paragon Dept No: 51535
Dept Name: McLaren Bay Orthopedic Surgery
Company Number: 210

Order Total Price: 16.75

Item Number: B-140
Item Description: Referral Form Bay Orthopedic Surgery
Revision Date: 01/2024
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Poster:
Misc Info: 8.5x11 black

McLaren
BAY REGION
ORTHOPEDIC SURGERY
4 Columbus Ave., Ste. 160
Bay City, MI 48708
Phone: (989) 369-2777 • FAX: (989) 684-6181

Referring Office to Complete and FAX to (989) 684-6181
PHYSICIAN REFERENCE
DR. RENDER | DR. O'JOHN | DR. LEWIS | First Available

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:
Car Accident? ☐ Yes ☐ No _____
Work Accident? ☐ Yes ☐ No (Month / Day / Year required)
Other Accident? _____
Family Physician? _____ Phone: _____ FAX: _____
Primary Insurance: _____ Subscriber: _____ D.O.B.: _____
Patient ID#: _____ G/EP#: _____ Effective Date: _____
Secondary Insurance: _____ Subscriber: _____ D.O.B.: _____
Patient ID#: _____ G/EP#: _____ Effective Date: _____
Please FAX this form back to us with labs, tests, notes, including other physician's notes, records, and any information pertaining to
In 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
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: _____

REFERRAL USE ONLY

Spec Info: Angie Claerhout -Bay Orthopedic Surgery Suite 160