McLaren
FLINT

McLaren Flint Thoracic Surgery Referral

Phone: (810) 342-2590

Fax: (810) 342-2591

Patient Diagnosis: _____

Patient Demographics

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Patient Phone Number: _____

Tests Completed

CT Scan ☐

CT Biopsy ☐

PET Scan ☐

PFT ☐

Pathology Reports ☐

YES or NO

Presented at tumor board ☐ ☐
If so, please attach recommendations.

Office Notes ☐

Pt demographics with current insurance information ☐

Lab work completed within 30 days ☐

When we receive your patient, we will FAX you their appointment date and time.

McLaren Flint Thoracic Surgery Appointment

Appointment Date: _____

Appointment Time: _____ With: _____