

McLaren Print System Order

Order No: 90357
Order Date: 2024-11-25
Order Request Date:
User: Angie Claerhout
Phone: 9896672802

Ship Location: Bay Spine Surgery
4175 N Euclid Ave Suite 9
Bay City, Michigan 48706

Brochures
Quantity: 100
Paragon Dept No: 56087
Dept Name: McLaren Bay Spine Surgery
Company Number:

Order Total Price: 3.35

Item Number: BAY-125
Item Description: SPINE SURGERY REFERRAL FORM
Revision Date: 11/2024
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Poster:
Misc Info: SS, Black

McLaren
Bay Spine Surgery
175 N. Euclid Ave. Suite 9, Bay City, MI 48706
(989) 937-2802 Fax (989) 937-2803
NEW PATIENT REFERRAL FORM

REFERRING OFFICE TO COMPLETE AND FAX
 DR. BRETT WALKER—SPINE SURGEON

TODAY'S DATE _____
PATIENT NAME _____ D.O.B. _____
ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
HOME PHONE _____ CELLWORK _____
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# _____ GROUP _____ EFFECTIVE DATE _____
SECONDARY INSURANCE _____ SUBSCRIBER _____ D.O.B. _____
PATIENT ID# _____ GROUP _____ EFFECTIVE DATE _____

Please fax this form back to us with lab, test, notes, including other physician's notes, records, and any information regarding the referral. Please include all insurance information and prior authorization that may be required. We will store 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.
3. Fax from: WFA, WPA, WPCA, WPCB, CT Surgery, OTHER _____

BAY REGION ORTHOPEDIC USE ONLY

Appointment Date _____ Time _____
Patient activation Date _____ Staff initials _____ Time _____
Referring provider verified Date _____ Staff initials _____ Time _____
New patient/return patient on Date _____ Staff initials _____ Time _____
Insurance verified Yes _____ No _____ Staff initials _____ Time _____

Spec Info: Original Poster Size