McLaren
BAY REGION

Bay Spine Surgery

4175 N. Euclid Ave. Suite 9, Bay City, MI 48706
(989) 667-2802 Fax: (989) 667-2803

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: _____ CELL/WORK: _____

REFERRING PHYSICIAN: _____ PHONE: _____ FAX: _____

REASON FOR REFERRAL: _____

IS THIS A RESULT OF: INJURY? ☐ YES ☐ NO
CAR ACCIDENT? ☐ YES ☐ NO
WORK ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY OR ONSET OF: _____ (Month / Day / Year required)

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

Appointment: Date: _____ Time: _____

Patient notification: Date: _____ Staff Initials: _____ Time: _____

Referring provider notified: Date: _____ Staff Initials: _____ Time: _____

New patient packet mailed on: Date: _____ Staff Initials: _____ Time: _____

Insurance Verified: Yes _____ No _____ Staff Initials: _____ Time: _____