McLaren Thumb Region General Surgery

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REQUEST FOR CONSULTATION

*****Please note the following:** Referring providers **MUST** complete all the necessary testing to support the referring diagnosis and results must be received by our office **AND** patients must be aware of above supported findings and reason for referral to our office prior to an appointment being scheduled. Thank you.***

Patients with CARDIAC HISTORY: We require the PCP to obtain CARDIAC CLEARANCE and ANTICOAGULANT THERAPY recommendations from the patient's cardiologist.

ABDOMINAL PAIN REFERRALS: A CT with contrast MUST be completed prior to referral

ANY referral pertaining to LOOSE STOOL or DIARRHEA MUST have a stool panel with C-DIFF completed

All information below MUST be included for referral processing:

- ☐ FULL PATIENT DEMOGRAPHICS
- ☐ LEGIBLE COPY OF INSURANCE CARDS (front and back)
- ☐ INSURANCE PRIOR AUTHORIZATION (if required)
- ☐ DIAGNOSTIC TESTING PERTAINING TO REFERRAL (ie. radiology, labs, etc.) **If imaging was done outside of McLaren, patient must bring disc to appointment*
- ☐ MOST RECENT OFFICE NOTE (pertaining to referral)
- ☐ PATIENT HISTORY (medical, family, surgical, social)
- ☐ *CURRENT* MEDICATION LIST
- ☐ CARDIAC CLEARANCE (if required)

Schedule with (please choose location and circle provider):

☐ BAD AXE- *1060 S. Van Dyke, Ste. 500, Bad Axe, MI*   ☐ CARO- *1800 W. Caro Rd., Ste. IV, Caro, MI*

Dr. D'Almeida   Dr. Hanks   Dr. McQuiston   Dr. Paulk   FIRST AVAILABLE

Referring Provider Information:

Name: ____

Address: ____________________ *City:* ____________ *State:* ____ *Zip:* ________

Office Phone: ____________________ *Office Fax:* ____________________

Patient Information:

Name: ______________________________ *DOB:* ______________

Address: ____________________ *City:* ____________ *State:* ____ *Zip:* ________

Home Phone: ____________________ *Cell Phone:* ____________________

REASON FOR REFERRAL: ____

DIAGNOSIS: ____

PATIENT IS SCHEDULED ON: ______________ ***AT*** __________ ***WITH DR.*** ______________