McLaren
BAY REGION
ORTHOPEDIC SURGERY
4 Columbus Ave., Ste. 160
Bay City, MI 48708
Phone: (989) 393-2777 • FAX: (989) 894-6181

Referring Office to Complete and FAX to (989) 894-6181

PHYSICIAN REFERENCE

DR. RENDER | **DR. D'JOHN** | **DR. LEWIS** | **First Available**

☐ Bay City ☐ Bay City

☐ West Branch ☐ Caro

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

Car Accident? ☐ Yes ☐ No

Work Accident? ☐ Yes ☐ No

Other Accident? _____

Date of Injury or Onset of:

_____

(Month / Day / Year required)

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: _____ Initials: _____ Time: _____

Referring Provider Notified: Date: _____ Initials: _____ Time: _____

New Patient packed mailed on: Date: _____ Initials: _____ Time: _____

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

REFERRAL USE ONLY