

Marquette General Medical Group Physician Practices

**CONSULTATION – REFERRAL REQUEST**

Date of Request: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Referring Physician Phone: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
(Street) (City) (State/Zip)

Patient Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

Patient Insurance/Managed Care Plan: \_\_\_\_\_  
(Contract/Recipient ID#) (Insurance Type)

Referred to: \_\_\_\_\_  
(Physician name) (Office Phone) (Office Fax)

Reason for **Referral** or **Consult** (Circle One) \_\_\_\_\_

Records To Be Sent: \_\_\_\_\_

Referral or Consult Letter Dictated  YES (*attach copy*)  NO

The following services are approved:

- \_\_\_ Consult only
- \_\_\_ Evaluation, testing and treatment as deemed appropriate for specific illness
- \_\_\_ Other: \_\_\_\_\_

Appointment request is **Urgent** (indicate timeframe \_\_\_\_\_)

Appointment Date/Time: \_\_\_\_\_

**Referrals to another specialist must be approved by the Primary Care Physician**  YES  NO

History:

Physical Findings:

Laboratory and X-ray Findings:

Medications or Procedures Already Utilized:

Most Recent Progress Note Attached

Please notify Dr. \_\_\_\_\_ of findings and/or recommended treatment.

Appointment made by: _____	Patient notified by: _____
Records sent by: _____	Date sent: _____