

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: _____