

Marquette General Medical Group Provider Practices

CONSULTATION – REFERRAL REQUEST

Date of Request: _____

Referring Provider: _____ Referring Provider 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: _____
(Provider name) (Office Phone) (Office Fax)

Reason for **Referral** or **Consult** _____

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

The following services are desired:

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

Appointment request is **Urgent** (indicate time frame _____)

Appointment Date/Time: _____

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

Please see attached copies of:

- Progress Notes
- Laboratory reports
- Radiology reports
- Procedures
- Medications/Allergy Sheet

Please notify Dr. _____ of findings and/or recommended treatment.

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