



REFERRAL FAX SHEET
FLINT FAX (810) 230-2086
SAGINAW FAX (989) 799-6471

Today's Date
Date of patient office visit/phone call to initiate referral

Referring PCP
Referring PCP ID Number
Office Staff Contact
Telephone
Fax

New Referral or Existing Referral

In-Plan: or Out-Of-Plan

Referral #

Patient's Contract # (suffix needed)

Patient's Name First Name Last Name

Date of Birth DD / MM / YY

#of office visits requested

Effective Dates of Referral to

Specialist's ID #

Specialist's Name First Last

Specialty

Procedure(s) Written Description

Location of Surgery: Office Outpatient Inpatient

Hospital

Ambulatory Surgery Center

Diagnosis Written Description

Additional comments

* Incomplete forms may be returned for completion *