WMED HEALTH

THE CLINICAL PRACTICE OF WESTERN MICHIGAN UNIVERSITY
HOMER STRYKER M.D. SCHOOL OF MEDICINE

Specialty Referral Form

Phone (269) 337-6289 Fax (269) 337- 6428 or 337-6547

Today's Date: _____

Specialty and/or physician to evaluate patient _____

Reason for request and Diagnosis _____

INDICATE URGENCY

☐ Urgent ☐ Routine

IS THIS RELATED TO:

☐ Auto ☐ Workers Comp ☐ Neither

Patient Name: _____ **Patient DOB**: _____

Patient Address: _____

Street City State Zip

Patient Social Security #_____ ☐ Male ☐ Female

Phone: _____ **Cell #** _____

Responsible Party (Must be completed) _____ **Phone:** _____

Responsible Party DOB _____

Does the patient need an Interpreter ☐ Yes ☐ No **If yes, what type of language?** _____

Primary Insurance: _____ **Secondary Insurance:** _____

Policy # _____**Group #** _____ **Policy #** _____**Group #** _____

Policy Holder: _____ **Policy Holder:** _____

Referring Physician: _____ MD/DO

Physician Full Address_____

Office Phone # _____ Office Fax: _____

Office Contact Person _____ Phone/ Extension _____

Primary Care Physician _____ PCP Phone _____ PCP Fax _____

******** Checklist for Information required with this referral Form*********

- **Copy of Patients Insurance Card (s) Front and Back**
- **Copy of the History and Physical & last two progress notes clarifying the cited purpose of this referral**
- **Current Medication List / Adverse Reactions**
- **Any Growth charts, Labs, Radiology Reports**