



# Henry Ford Specialty Center - Saginaw

Phone: (877) 434-7470 • Fax: (313) 916-5717

## REFERRAL FORM

Date: \_\_\_\_\_ Form completed by: \_\_\_\_\_

New patient       Updated patient information (if updated information please fill out name, date and date of birth only unless changes have occurred)

Patient name \_\_\_\_\_ DOB (Date of birth) \_\_\_\_\_  
(last) (first)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Alt. Phone \_\_\_\_\_

Diagnosis \_\_\_\_\_

Reason for referral \_\_\_\_\_

Provider Requested (if known): \_\_\_\_\_

Timeframe?  Urgent / Next Available     Routine

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_ Email \_\_\_\_\_

### INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following):

Primary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_

Insurance company name \_\_\_\_\_

ID/Policy # \_\_\_\_\_ Group \_\_\_\_\_ Phone \_\_\_\_\_

Employer name \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_

Insurance company name \_\_\_\_\_

ID/Policy # \_\_\_\_\_ Group \_\_\_\_\_ Phone \_\_\_\_\_

### Please fax referral form and the following prior to patient appointment at (313) 916-5717:

Pertinent biopsy reports     Pertinent consult notes     Pertinent lab reports     Pertinent imaging reports (CT, MRI, X-ray)

## QUESTIONS? CALL (877) 434-7470