McLaren
BAY REGION

BAY NEUROLOGY
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REFERRING OFFICE TO COMPLETE AND FAX

TODAY'S DATE: _____

PATIENT NAME: _____ D.O.B.: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL/WORK: _____

REFERRING PHYSICIAN: _____ PHONE: _____ FAX: _____

REASON FOR REFERRAL: _____

FAMILY PHYSICIAN: _____ PHONE: _____ FAX: _____

PRIMARY INSURANCE: _____ SUBSCRIBER: _____ D.O.B.: _____

PATIENT ID#: _____ GRP#: _____ EFFECTIVE DATE: _____

SECONDARY INSRUANCE: _____ SUBSCRIBER: _____ D.O.B.: _____

PATIENT ID#: _____ GRP#: _____ EFFECTIVE DATE: _____

1. **Does the Patient's insurance require a referral and/or authorization? YES / NO**
   If Yes, please send a copy of the authorized referral.
2. **Testing done: EMG/NCS MRI MRA CT EEG LABS OTHER:** _____

Please FAX this form back to us with labs, tests, notes, including other physicians' notes, records and any information pertaining to this referral. Please include all insurance information and prior authorization that may be required. We will review all information prior to contacting the patient with a scheduled appointment.

BAY NEUROLOGY USE ONLY

Appointment Date: _____ Time: _____

Patient Notified: Date: _____ Staff Initials: _____

Referring provider notified: Date: _____

New patient packet mailed on: _____ Date: _____ Staff Initials: _____

Insurance Verified: Yes: _____ No: _____ Method: _____