BAY REGION
ORTHOPEDIC SURGERY

4 Columbus Ave., Ste. 160
Bay City, MI 48708
Phone: (989) 393-2777 • FAX: (989) 894-6181

Referring Office to Complete and FAX to (989) 894-6181

PHYSICIAN REFERENCE

DR. RENDER | DR. D'JOHN | DR. LEWIS | First Available

Today's Date: ____________________

Patient Name: ____________________ D.O.B.: ____________________

Address: ____________________ City: ____________________ State: ________ Zip Code: ____________

Home Phone: ____________________ Cell/Work: ____________________ Email Address: ____________________

Referring Physician: ____________________ Phone: ____________________ FAX: ____________________

Reason for Referral: ____________________

Is this a result of: Injury? ☐ Yes ☐ No

Car Accident? ☐ Yes ☐ No

Work Accident? ☐ Yes ☐ No

Date of Injury or Onset of:

____

(Month / Day / Year required)

Other Accident? ____________________

Family Physician? ____________________ Phone: ____________________ FAX: ____________________

Primary Insurance: ____________________ Subscriber: ____________________ D.O.B.: ____________________

Patient ID#: ____________________ GRP#: ____________________ Effective Date: ____________________

Secondary Insurance: ____________________ Subscriber: ____________________ D.O.B.: ____________________

Patient ID#: ____________________ GRP#: ____________________ Effective Date: ____________________

Please FAX this form back to us with labs, tests, notes, including other physician's 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.

1. **Does patient's insurance require a referral and/or authorization? YES / NO**

   Referral number and/or copy of referral: ____________________

2. **Referring office to circle tests completed and FAX results:**

   X-ray; Bone Scan; MRI; MRA; EMG/NCS; CT; Surgery; Other: ____________________

BAY REGION ORTHOPEDIC USE ONLY

Appointment Date: ____________________ Time: ____________

Patient Notification: Date: ____________ Initials: ________ Time: ____________

Referring Provider Notified: Date: ____________ Initials: ________ Time: ____________

New Patient packed mailed on: Date: ____________ Initials: ________ Time: ____________

Insurance Verified: Yes ______ No ______ Initials: __________ Time: __________

REFERRAL USE ONLY