McLaren Bay Infectious Disease
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Referral Form

Patient Name Last: _____First: _____

Gender: Male _____ Female _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Referring Provider: _____ Office Contact: _____

Phone: _____ Fax: _____

Insurance-Send Copy of Insurance Card OR Demographic Page

Is Authorization Needed? No: _____ Yes: _____

Authorization Number: _____ Effective Dates: _____ to _____

Reason for Referral: _____

SEND ALL RECORDS AND DIAGNOSTIC TESTING PERTAINING TO REASON FOR REFERRAL

Comments: _____
