McLaren Bay Pulmonology and Critical Care
714 S. Trumbull, Suite 200
Bay City, MI 48708
Ph: 989 316-4010 F: 810 600-7694

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: ____

Provider Preference: Dr Kwon ____ Dr Iftikhar ____ First Available _____

SEND ALL RECORDS AND DIAGNOSTIC TESTING PERTAINING TO REASON FOR REFERRAL

Patient will need a Pulmonary Function Test prior to appointment for the following:

Shortness of Breath, Cough, Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, Restrictive Lung Disease, Pulmonary Fibrosis, Interstitial Lung Disease, Surgical Clearance

Comments: ____

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