

Fax Referral Form

To	Referred to (Specialty Clinic or Service): _____ (Please Print) Physician Name / Location: _____ (Optional)
From	Referring Physician: _____ Office Name: _____ (Please Print) Office Contact: _____ Phone#: (_____) _____ Fax#: (_____) _____ E-Mail Address: _____
PCP (If different from Referring)	Physician Name: _____ Office Name: _____ (Please Print) Office Contact: _____ Phone#: (_____) _____ Fax#: (_____) _____ E-Mail Address: _____
Patient Information	Last Name: _____ First Name: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F _____ DOB: _____ Telephone: Home: (_____) _____ Mobile: (_____) _____ Address: _____ City: _____ State: _____ Zip: _____
Special Accommodations	Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, language: _____ Ambulatory Assistance: <input type="checkbox"/> wheelchair <input type="checkbox"/> Other: _____ Other Special Needs: _____
Other Contact Information (if applicable)	Parent/Guardian Name: _____ Relationship: _____ Telephone: Home: (_____) _____ Mobile: (_____) _____
Insurance Information (attach ins. card)	Insurance: _____ <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Traditional <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-Pay <input type="checkbox"/> Auto Accident: Date of Injury _____ <input type="checkbox"/> Work Comp: Date of Injury _____
Appointment Requested:	<input type="checkbox"/> Urgent <input type="checkbox"/> Next Available <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 1 week <input type="checkbox"/> Other: _____
Diagnosis and Reason for Referral	<input type="checkbox"/> Consult only <input type="checkbox"/> Consult and Treatment <input type="checkbox"/> Second Opinion ICD-10 Code: _____ Diagnosis Description: _____ Signs/symptoms: _____ Records must be included if you don't have access to University of Michigan Health-West Epic
Requesting Physician	Physician Signature: (Required for PT/OT/ST and diagnostic test only) _____ (Signature) _____ (Date)

Thank you for the referral