Fax completed form directly to the office

METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

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:** ☐ **M** ☐ **F** _____ **DOB:**_____ **Telephone:** Home: (_____) _____ Mobile: (_____) _____ **Address:** _____**City:** _____**State:**_____ **Zip:**_____
Special Accommodations	**Interpreter:** ☐ Yes ☐ No If yes, language:_____ **Ambulatory Assistance:** ☐ wheelchair ☐ Other: _____ **Other Special Needs:** _____
Other Contact Information (if applicable)	**Parent/Guardian Name:** _____**Relationship:**_____ **Telephone:** Home: (_____) _____ Mobile: (_____) _____
Insurance Information (attach ins. card)	**Insurance:**_____ ☐ HMO ☐ PPO ☐ POS ☐ Traditional ☐ Medicare ☐ Medicaid ☐ Self-Pay ☐ **Auto Accident:** Date of Injury_____ ☐ **Work Comp:** Date of Injury_____
Appointment Requested:	☐ **Urgent** ☐ **Next Available** ☐ **Within 2 weeks** ☐ **Within 1 week** ☐ **Other**:_____
Diagnosis and Reason for Referral	☐ **Consult only** ☐ **Consult and Treatment** ☐ **Second Opinion** **ICD-10 Code:** _____ **Diagnosis Description:** _____ **Signs/symptoms:**_____ **Records must be included if you don't have access to Metro Health Epic**
Requesting Physician	**Physician Signature:** (Required for PT/OT/ST and diagnostic test only) _____ (Signature) (Date)

Thank you for the referral