PATIENT REFERRAL FORM

FAX YOUR REFERRALS TO 616-956-6637

DATE_____

REFERRED TO (OPTIONAL)_____

PATIENT INFORMATION

Patient's First Name_____

Last Name_____

DOB___/___/___ Gender: Male ❑ Female ❑

Address _____

_____

Daytime Phone (_____)_____

Alternate Phone (_____)_____

MEDICAL INFORMATION

Diagnosis/Reason for referral _____

_____

_____

Patient's Height _____ Weight _____

And/or

Patient's BMI _____

Would you like to be notified when appointment is scheduled? Yes❑ No❑

INSURANCE INFORMATION

Health Plan _____

Member ID _____

Group # _____

Authorization # _____

Secondary Insurance, if any_____

REFERRING DOCTOR CONTACT INFORMATION

Name _____

Phone (_____)_____

Fax (_____)_____

Office Name _____

ATTACHMENTS

❑ Pertinent Medical/Operative Notes

❑ Pertinent Lab Studies

❑ Proof of any previous weight loss attempts