PRINT FORM CLEAR FORM

HENRY FORD HEALTH

Henry Ford Referring Physician Office

Phone: (877) 434-7470 • Fax: (313) 916-5717

REFERRAL FORM

Date: _____ Form completed by: _____

☐ New patient ☐ Updated patient information (if updated information please fill ot name, date and date of birth only unless changes have occurred)

Patient name _____ DOB (Date of birth) _____

(last) (first)

Address _____

City _____ State _____ Zip _____

Phone _____ Alt. Phone _____

Diagnosis _____

_____

Location Preference:

☐ Jackson/HFAH ☐ Detroit/HFH ☐ Macomb/HFMH ☐ Wyandotte/HFWH ☐ West Bloomfield/HFWBH

Locations will be offered where the services referred for are rendered, patients will select the location that is most convenient.

Reason for referral _____

Provider Requested (if known): _____

Timeframe? ☐ Emergent ☐ Urgent ☐ 1-2 Days ☐ 3-5 Days ☐ 1-2 Weeks ☐ Routine/1st Available

Referring Physician _____ Primary Care Physician _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Phone _____ Phone _____

Fax _____ Fax _____

Email _____ Email _____

INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following):

Primary Insurance _____ Policy Holder _____

Insurance company name _____

ID/Policy # _____ Group _____ Phone _____

Employer name _____

Secondary Insurance _____ Policy Holder _____

Insurance company name _____

ID/Policy # _____ Group _____ Phone _____

Please fax referral form and the following prior to patient appointment at (313) 916-5717:

☐ Pertinent biopsy reports ☐ Pertinent consult notes ☐ Pertinent lab reports ☐ Pertinent imaging reports (CT, MRI, X-ray)

QUESTIONS? CALL (877) 434 7470