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	
	State Zip
Phone	Alt. Phone
Diagnosis	
Locations will be offer	Detroit/HFH 🗌 Macomb/HFMH 🗌 Wyandotte/HFWH 🗌 West Bloomfield/HFWBH ed where the services referred for are rendered, patients will select the location that is most convenient.
	known):
	ent 🗌 Urgent 🔲 1-2 Days 🗌 3-5 Days 🗌 1-2 Weeks 🗌 Routine/1st Available
	Primary Care Physician
Address	Address
City, State, Zip	City, State, Zip
Phone	Phone
Fax	Fax
Email	Email
INS	JRANCE (attach copy of all insurance card(s) Front and Back and complete the following):
Primary Insurance	Policy Holder
Insurance company na	ne
ID/Policy #	Group Phone
Employer name	
	Policy Holder
Insurance company nar	ne
	Group Phone
	n and the following prior to patient appointment at (313) 916-5717:
Pertinent biopsy re	oorts 🔲 Pertinent consult notes 🔲 Pertinent lab reports 📄 Pertinent imaging reports (CT, MRI, X-ray)