

## Henry Ford Specialty Center - Ishpeming Phone: (877) 434-7470 • Fax: (313) 916-5717

New patient   Updated patient information (if updated information please fill of name, date and date of birth only unless changes have occurred Patient name	Date:	Form completed by:		
Address   State	☐ New patient ☐ Updated patien	t information (if updated information please fill ot	name, date and date of birth only unless changes have occurred	
Address   State	Patient name		DOB (Date of birth)	
City State Zip Phone Alt. Phone Diagnosis  Reason for referral Provider Requested (if known): Timeframe?				
City State Zip Phone Alt. Phone Diagnosis  Reason for referral Provider Requested (if known): Timeframe?	Address			
Diagnosis   Diag			Zip	
Reason for referral	Phone	Alt. Phone		
Provider Requested (if known):  Timeframe?  Urgent / Next Available  Routine  Referring Physician  Primary Care Physician  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  Secondary Insurance  Policy Holder  Insurance company name  Employer name  Secondary Insurance  Policy Holder  Insurance company name  Group  Phone  Phone	Diagnosis			
Timeframe? Urgent / Next Available Routine  Referring Physician Primary Care Physician  Address Address  City, State, Zip  Phone Phone Fax Fax  Email  INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following):  Primary Insurance Insurance company name  ID/Policy #  Group Policy Holder  Insurance company name  Employer name  Secondary Insurance Policy Holder  Insurance company name  Fax  Group Phone Phone Phone Phone Phone Phone Phone Phone	Reason for referral			
Timeframe? Urgent / Next Available Routine  Referring Physician Primary Care Physician  Address Address  City, State, Zip City, State, Zip Phone Phone Fax Fax  Email INSURANCE (attach copy of all insurance card(s) Front and Back and complete the following):  Primary Insurance Insurance company name ID/Policy # Group Policy Holder Insurance Company name  Employer name  Secondary Insurance Policy Holder  Insurance company name  Fax Group Phone				
Address				
City, State, Zip City, State, Zip	Referring Physician	Primary Care Physic	Primary Care Physician	
Phone Phone Phone	Address	Address	Address	
Fax	City, State, Zip	City, State, Zip	City, State, Zip	
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	Phone	Phone	Phone	
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  Secondary Insurance Policy Holder Insurance company name  ID/Policy # Group Phone	Fax	Fax	Fax	
Primary Insurance         Policy Holder           Insurance company name         Group         Phone           ID/Policy #         Folicy Holder           Secondary Insurance         Policy Holder           Insurance company name         Group         Phone	Email	Email	Email	
Insurance company name	INSURANCE (attach copy o	f all insurance card(s) Front and B	ack and complete the following):	
ID/Policy #         Group         Phone           Employer name         Policy Holder           Secondary Insurance         Policy Holder           Insurance company name         Group         Phone	Primary Insurance	Policy Holder	Policy Holder	
Employer name  Secondary Insurance Policy Holder  Insurance company name  ID/Policy # Group Phone	Insurance company name			
Secondary Insurance Policy Holder  Insurance company name  ID/Policy # Group Phone			Phone	
Insurance company name   Group   Phone	Employer name			
ID/Policy #	Secondary Insurance	Policy Holder		
	Insurance company name			
	ID/Policy#	Group	Phone	

REFERRAL FORM