



Bassam Afaneh, MD, FAAPC
Anishka Rolle, MD, RhMSUS
Kari Nothstine, MSN, APRN, FNP-C

Ann Connaughan, MD
Elizabeth Morrison, DO

Referral Form: Family Practice

P: (989) 341-5078 | F: (989) 341-5073

Locations

Caro Bad Axe Cass City Saginaw

Thank you for choosing to refer your patient to us. Please include brief pertinent medical records and test results that support the consultation. Please call (989) 341-5078 regarding any questions.

Date: _____ From: _____
Number of Pages: _____ Title: _____
Referring Provider: _____ Phone: _____
Fax: _____ Fax: _____

PATIENT INFORMATION

Name of Patient: _____
DOB: _____ Interpreter needed: Yes No Language: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
If Child, Name of Parent: _____ DOB: _____
Address: _____
Street City State Zip

Insurance: Include patient's insurance card (both sides) and HMO authorization if required.

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD10: _____
Name of M.D. (if known): _____
Reason for Consultation: _____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

CONSULTATION REQUEST INFORMATION

Referring M.D.: _____ Specialty: _____
Phone: _____ Fax: _____
PCP Name: _____ Phone: _____
Signature: _____

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy, or otherwise disseminate any of the information contained herein.