Western Michigan University
Homer Stryker M.D.
SCHOOL OF MEDICINE

Specialty Referral Form

Phone: (269) 337-6289 Fax: (269) 337-6547

***** Please include a current History and Physical, any office notes, lab and/or radiology results, growth charts, current medications, problems list, SMOKING HISTORY, and/or treatments attempted, that pertain to this consult request. If this information is not included, and this form is not COMPLETELY filled out, your request WILL NOT BE PROCESSED.*****

Specialty and/or physician to evaluate patient: _____ Today's Date: _____

Reason for request (Diagnosis): _____

INDICATE URGENCY:

☐ Urgent ☐ Routine

IS THIS RELATED TO:

☐ Auto ☐ Workers' Comp ☐ Neither

Patient Name: _____ Patient DOB: _____

Patient's Social Security #: _____ ☐ Male ☐ Female

Patient's Address: _____

Street City State Zip

Primary Phone #: _____ Secondary Phone #: _____

Responsible Party (MUST BE COMPLETED): _____ Phone: _____

Responsible Party Date of Birth: _____

Does the patient require an interpreter? ☐ Yes ☐ No If yes, what type/language? _____

Primary Insurance: _____ **Secondary Insurance:** _____

Group #: _____ Policy #: _____ Group #: _____ Policy #: _____

Policy Holder: _____ Policy Holder: _____

SS#: _____ DOB: _____ SS#: _____ DOB: _____

****** Please include a LEGIBLE copy of the insurance ID card, front and back ******

Referring Physician: _____ MD/DO

Physician's Full Address: _____

Office Phone #: _____ Office Fax #: _____

Contact Person: _____ Department: _____ Phone/Extension: _____

Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____

Form Revised 08/19/15

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