McLaren
BAY REGION

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McLaren Bay Region – General Surgery Referral Form

All referrals *MUST* include this completed form along with patients' most recent labs, EGD, colonoscopy, x-rays, CT scans, ultrasounds, hospital records, office notes, BCN Global Auth, if needed and any other records pertaining to the diagnosis *before the patient will be scheduled*. Thank You.

Please check the appropriate box: **COLONOSCOPY** ☐ **EGD** ☐ **OFFICE VISIT** ☐

Diagnosis: _____

Referring Physician: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT INFORMATION - *Complete Thoroughly OR Send Patient Demographics Page*

Patient Name **Last:** _____ **First:** _____

Gender: Male ☐ Female ☐ **Date of Birth:** _____

Address: _____ City: _____ Zip: _____

Phone: _____ Cell: _____

Name of Guardian (if applicable): _____

Address: _____ City: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

INSURANCE – *Include Legible Copy of Insurance Card Front & Back*

PRIMARY INSURANCE ***Global Referral Number if BCN:*** _____

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____

Insurance: _____ Policy #: _____ Group#: _____

SECONDARY INSURANCE

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____

Insurance: _____ Policy #: _____ Group#: _____

Additional Comments: _____

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