GRAND HEALTH PARTNERS
TRANSFORMATIONS HAPPEN DAILY

NEW PATIENT REFERRAL FORM

FAX YOUR REFERRALS TO 616-956-6637

DATE _____

REFERRED TO (circle one): **Colonoscopy or Endoscopy** **General Surgery** **Weight Loss**

Please NOTE: Patients must weigh *less than 500lbs* and *NOT be wheelchair-bound* for a colonoscopy or endoscopy.

PATIENT INFORMATION

First Name_____

Last Name_____

DOB___/___/___ Gender: Male ❑ Female ❑

Address _____

_____

Cell Phone (___ __)_____

Home Phone (___ __)_____

MEDICAL INFORMATION

Diagnosis/Reason for referral _____

_____

_____

Patient's Height _____ Weight _____

AND/OR

Patient's BMI _____

Would you like to be notified when appointment is scheduled? Yes❑ No❑

Contact Method: _____

INSURANCE INFORMATION

Some insurance plans require prior authorization obtained by the PCP. Please verify with insurance.

Health Plan _____

Member ID _____

Group # _____

*Authorization #_____

Secondary Insurance, if any_____

REFERRING DOCTOR CONTACT INFORMATION

Name _____

Phone (_____)_____

Fax (_____)_____

Office Name _____

ATTACHMENTS

❑ Pertinent Medical/Operative Notes (*If referring patient for a colonoscopy please include prior colonoscopy procedure note and any biopsy results*.)

❑ Pertinent Lab Studies

❑ Documentation of Previous Weight Loss Attempts