Consultation Request

**Dr. Matthew K Thomson Dr. James R Toney Dr. Jonathon Rayman Dr. Michael Dziewit**

**First Available**

Location (circle): Lansing or Corunna/Owosso or St. Johns

Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHONE NUMBER:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance (Medicaid – Must call first):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note: Medicaid or county health plans are accepted on a case by case basis

**\*\*\*MUST SEND COPY OF INSURANCE CARD(S)\*\*\***

Needs to be seen: ASAP (Please Call) \_\_\_\_\_\_\_\_\_ Routine (1-2 weeks) \_\_\_\_\_\_\_\_\_\_

**Today’s Date:**

**Reason for Referral:**

Please send H&P, progress notes, relevant labs and imaging studies, and copy of driver’s license and insurance information.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fax to**: 517 – 882 - 3935**