Consultation Request

**Dr. Matthew K Thomson Dr. James R Toney Dr. John K Throckmorton**

**First Available**

Location (circle): Lansing or Owosso

Referring Physican:

Patient Information: **PHONE NUMBER AND ADDRESS:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**