ADVANCED OB-GYN
Obstetrics & Gynecology
230 Michigan St. NE, Suite 102
Grand Rapids, MI 49503
Phone: (616) 971-0060
Fax: (616) 301-9899

NEW PATIENT REFERRAL FORM

Full first and last name: _____ DOB_____
Previous name(s): _____
Phone: _____
Home Address: _____
_____
Insurance: _____
Policy holder, if not patient:_____ DOB_____
Contract No.: _____ Group No.: _____
***** We do NOT participate with Medicaid or affiliated Medicaid programs & cannot accept patients with primary or secondary Medicaid.*****

Referring Provider: _____
Referring Office Phone: _____
Referring Office Fax: _____
Referral Coordinator/Office Contact (name and #):_____
Please select applicable service request: New Patient Evaluation: _____ Consultation: _____
Clinical Reason for Referral: _____
_____
_____
Patient's PCP, if not the referring provider:_____

The following required documentation must accompany all referrals:

- All relevant appointment notes
- Laboratory studies completed within the last 6 months
- Pathology reports (including pap results) completed within the last 6 months
- Imaging studies completed within the last 6 months
- For ESSURE consultations, referrals MUST include the surgical report and an X-ray or other imaging documenting the location of the ESSURE device

Please fax patient information along with relevant medical records which indicate the reason for referral.
Note: We do not use Epic and cannot access referrals or records that are interfaced through Epic.
All documents must be faxed to the number below.
Fax: (616) 301-9899