



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: _____ HMO / PPO / EPO / POS (circle if applicable) Ins state: _____

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
- Latest pap results
- 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