ADVANCED OB-GYN
Obstetrics & Gynecology
230 Michigan St. NE, Suite 102, Grand Rapids, MI 49503 616-971-0060

NEW PATIENT REFERRAL FORM

Full first and last name: _____ D.O.B._____

Previous name(s): _____

Phone: _____

Home Address: _____

We DO NOT participate with Medicaid or other affiliated Medicaid programs.

Insurance: _____

Policy holder, if not patient:_____ DOB_____

Contract No.: _____ Group No.: _____

Referring Provider: _____

Referring Office Phone: _____

Referring Office Fax: _____

Primary Care Provider: _____

(Please select applicable service request:) New Patient Evaluation: _____ Consultation: _____

Clinical Reason for Referral: _____

_____

_____

Required documentation for all incoming referrals:

- Any relevant appointment notes
  - For ESSURE consultations, you MUST send the office the surgical report
- Any relevant laboratory studies, completed within the last 6 months
- Any relevant pathology reports, completed within the last 6 months
- Any relevant imaging studies, completed within the last 6 months
  - For ESSURE consultations, you MUST send the office 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 obstetrics or gynecologic referral.