



Physician Request Form

Main Campus - 1560 Turf Lane
 East Lansing, MI 48823
 South Campus – 1100 S. Cedar Street
 Mason, MI 48854
 Phone 517-484-3000
 Fax 517-492-0386

Thank you for the referral of your patient!

ASAP REFERRAL – Patient will be scheduled with first available provider in 1 week.

Today's Date: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Insurance (PLEASE SEND A COPY OF CARDS): _____

If an authorization is required, please include that with the request form

Referring Physician: _____ Contact Person: _____

Address: _____ City: _____ State: _____ Zip: _____

Private Line: _____ Fax: _____

Meaningful Use Stage 2 - Core Measure 15

The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.

Our office would like to send you a summary of care through direct messaging, please provide the listed referring physician above direct message address: _____

Referring Diagnosis (PLEASE BE SPECIFIC):	PLEASE INCLUDE PERTINENT RECORDS, SUCH AS:
	<ul style="list-style-type: none"> Labs Ultrasound reports Office notes

LOCATION:	<input type="checkbox"/> East Lansing – Main Campus	<input type="checkbox"/> Mason – South Campus
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Physician or Nurse Practitioner Preference:		
Obstetrics/Gynecology <input type="checkbox"/> Erica Leigh Behring, M.D. <input type="checkbox"/> Sara Cramton, MD <input type="checkbox"/> Stephanie Fleming, MD <input type="checkbox"/> Melissa Halvorson, MD <input type="checkbox"/> Sharon Kelley, MD <input type="checkbox"/> Kevin London, MD <input type="checkbox"/> Renee Stevens, DO <input type="checkbox"/> Elizabeth Thomas, MD <input type="checkbox"/> LaKeya Tucker, DO	<input type="checkbox"/> Abby Brown, CNM, NP <input type="checkbox"/> M. Elizabeth Cross, CNM <input type="checkbox"/> Nicole Jamieson, RN, NP <input type="checkbox"/> Laura Kelly, RN, NP <input type="checkbox"/> Susan Mackenzie, CNM, NP <input type="checkbox"/> Sameerah Shareef, CNM <input type="checkbox"/> Diane Strachan RN, NP <input type="checkbox"/> Stacey Tanay, RN, NP <input type="checkbox"/> Jennifer Thomas, RN, NP <input type="checkbox"/> No Preference	Urogynecology <input type="checkbox"/> Todd Moyerbrailean, DO Gynecology <input type="checkbox"/> Maude Guerin, MD

Please Note: Your patient will receive a packet of information that must be filled out and brought to the appointment. Thank you for the referral. Please call our office if you have any questions.

PLEASE MAKE COPIES OF THIS FORM FOR FUTURE USE