UNIVERSITY OF MICHIGAN
HEALTH-SPARROW
MICHIGAN MEDICINE

Specialty Referral Form

Patient Information ***(Please Attach Face Sheet)***	Last Name: _____First Name:_____ DOB: _____ Gender: M ☐ F ☐ Patient's Phone#: (_____)_____ Interpreter: Yes / No If yes, language: _____
To	Referred to (Specialty Clinic or Service): _____ (Please Print) Physician Name / Location: _____ (Optional)
From	Referring Provider: _____ Office Name: _____ (Please Print) Office Contact: _____ Phone#: (_____)_____ Fax#: (_____)_____ E-Mail Address: _____
PCP ***(If Different from Referring Provider)***	Primary Care Provider: _____ Office Name: _____ (Please Print) Office Contact: _____ Phone#: (_____)_____ Fax#: (_____)_____ E-Mail Address: _____
Insurance Information ***(Attach Copy of Insurance Card and Authorization if required)***	Primary Insurance: _____ Secondary Insurance_____ Authorization Number: _____ ***Authorization number MUST be attached if required, otherwise referral request will be returned**
Appointment Requested	☐ Urgent (1-3 days) ☐ Acute (5-10 days) ☐ Routine (first available, within 3 month)
Diagnosis and Reason for Referral	Diagnosis Code/Description: _____ _____ Signs/Symptoms: _____ Implant Device: Make _____ Model_____ Date Device Placed_____ Other Notes/Comments: _____ ***Records MUST be included if you do not have access to University of Michigan Health–Sparrow EPIC**

Scan the QR code and tap the link to learn more about our medical group specialists.

Find the right highly skilled specialist @ UofMHealthSparrow.org