Gerald R. Schell, M.D.

Referral Request Form

Scheduled On: _____Patient Notified of Appointment: YES NO

Requesting Physician:_____ Office Contact: _____

Referring Office Phone:_____Fax:_____

Reason For Visit: _____

Patient's Last Name: _____ First Name:_____ MI:_____

SSN:_____ Date of Birth: _____ Male ___ Female ___

Patient Address: Street: _____ Apt/Suite/P.O.Box: _____

City:_____ State: _____ Zip:_____

Phone:_____ ALT. Phone: _____

Insurance:

Work/Auto Claim #:_____Date of Injury: _____

Primary Insurance: _____ ID Number: _____

Secondary Insurance: _____ ID Number: _____

Patients Preferred Location: Bad Ax____ Bay City____ Caro____ Deckerville____ Lapeer____

Marlette____ Roger City____ Saginaw____ West Branch____

- **PLEASE FAX REFERRAL REQUEST FORM ALONG WITH AUTHORIZATION (IF APPLICABLE), MOST RECENT OFFICE NOTE, ANY RELEVANT IMAGING, CONSERVATIVE TREATMENT/PROCEDURE NOTES, AND DEMOGRAPHICS WITH INSURANCE INFORMATION TO 989-799-0222.**
- **OUR OFFICE WILL SCHEDULE DIRECTLY WITH THE PATIENT. THANK YOU FOR YOUR REFFERAL!**