



FAX REFERRAL

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 Renuka Heddurshetti, M.D.
 Elizabeth Hale, M.D.
 Michael J. Kennedy, M.D.
 Romal Bhan, M.D.
 Tejal Mehta, M.D.

Please fax this form along with **patient's face sheet** for Demographic and Insurance information to the appropriate office. Also, include **any recent labs, cultures and referring physicians orders and/or any other information if needed.**

- Farmington Hills** 24350 Orchard Lake Rd., Suite 111 • Farmington Hills, MI 48336
Phone **248.615.0889** • Fax 248.615.9952
- Westland** 35270 Nankin Blvd., Suite 501 • Westland, MI 48185
Phone **734.513.8688** • Fax 734.513.8687
- Southgate** 14510 Northline Road • Southgate, MI 48195
Phone **734.282.2800** • Fax 734.282.2828
- Rochester Hills** 1854 West Auburn Rd., Suite 200 • Rochester Hills, MI 48309
Phone **248.853.2323** • Fax 248.853.8890
- Sterling Heights** 5280 Metropolitan Pkwy. • Sterling Heights, MI 48310
Phone **586.446.8688** • Fax 586.446.9994
- Clarkston** 5701 Bow Pointe Dr., Suite 245 • Clarkston, MI 48346
Phone **248.625.9900** • Fax 248.625.9903

PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE

DATE ___ / ___ / _____

REFERRING PHYSICIAN _____ PHONE # _____

PRIMARY CARE PHYSICIAN _____

FACILITY / OFFICE ADDRESS _____

REASON FOR REFERRAL _____

PATIENT DIAGNOSIS _____

PATIENT NAME _____ PHONE # _____

PATIENT SS # _____ D.O.B. ___ / ___ / _____ CELL # _____

WOUND CARE INSTRUCTIONS (Products/Dressings) OR OTHER

PRIMARY INSURANCE _____ INSURED ID# _____ GROUP# _____

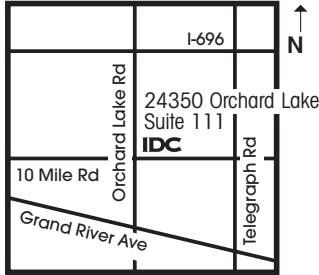
SUBSCRIBER'S NAME _____ SELF SPOUSE DEPENDENT

SECONDARY INSURANCE _____ INSURED ID# _____ GROUP# _____

SUBSCRIBER'S NAME _____ SELF SPOUSE DEPENDENT

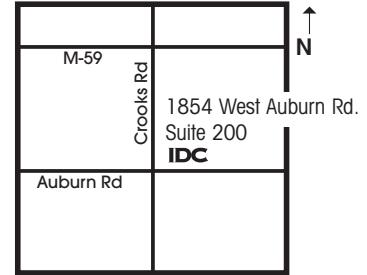
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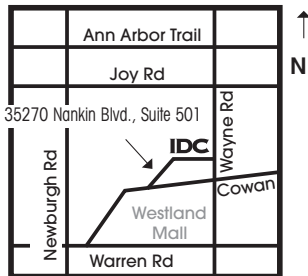
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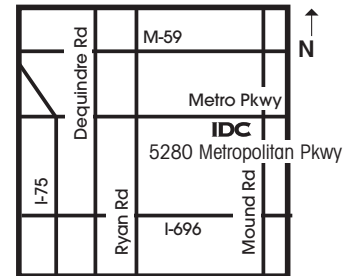
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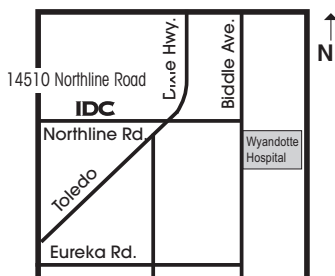
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□ Southgate

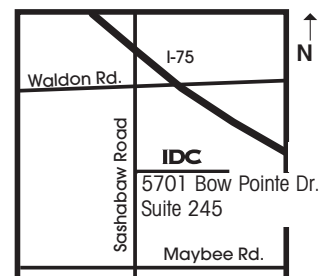
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Medical Building

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