GRAND RAPIDS THORACIC SURGERY

LOURENS J WILLEKES II, MD

Referral Form

Please complete this form and FAX to: (616) 259-7642

Today's Date: _____

Referring Provider: _____ Referring Office Name: _____

Referring Provider Phone #: _____ Office FAX #: _____

Patient's Name: _____ Patient's DOB: _____

Patient's Address: _____

Patient's Phone #: _____ Patient's SSN: _____

Patient's Insurance: _____

Authorization number: _____

Reason for Referral (please be specific): _____

_____

Please Note:

- The following information is helpful: Most recent CT scan, PET scan, X-rays, and Pathology and if possibly, please have the patient bring films or CD's.
- Please include office notes, surgery reports, any additional information regarding this referral.
- Please send Insurance Authorization information, as required by the Patient's insurance, along with this referral.
- We will notify patient by phone of appointment time and date.

Thank you for your referral. Feel free to call us with any questions or concerns.

4500 CASCADE RD. SUITE 210 GRAND RAPIDS, MI 49546
PHONE: 616-259-7341 FAX: 616-259-7642