UP HEALTH SYSTEM MARQUETTE
A Duke LifePoint Hospital

Specialty Clinic
UPHS Marquette – Medical Office Bldg.
850 W Baraga Avenue Suite 31
Marquette, MI 49855

SPECIALTY CLINIC REFERRAL FORM

Please fax this request to the
Specialty Clinic at (833)673-0349
Phone Number (906) 449-4880

Clinic(s) Requested _____ **Date of Request** ____/_____/____

Patient Name _____ **Date of Birth** _____/_____/_____ SEX: ☐ **MALE** ☐ **FEMALE** ☐ **OTHER** _____

Parent Name (Mother) _____ Date of Birth _____/_____/_____

Street Address _____ City _____ State____ Zip Code_____

Home Phone _____ Cell Phone _____ **Child lives with**: ☐ **Yes** ☐ **No**

Parent Name (Father) _____ Date of Birth _____/_____/_____

Street Address _____ City _____ State____ Zip Code_____

Home Phone _____ Cell Phone _____ **Child lives with**: ☐ **Yes** ☐ **No**

Insurance _____ **Policy #** _____ **Group #** _____

Policy Holder Name _____ **Policy Holder date of birth** _____/_____/_____

Referred By _____ Referring Office Physician _____

Office Contact _____ Phone Number _____ Fax Number _____

Reason for Referral/Chief Complaint (**please include dx codes**) _____

_____

Fax physician notes, EKG/Echo, MRI/CT, Labs, X-Rays and GROWTH CHARTS with this referral form.

Appointment Date _____ **Appointment Time** _____

□ **PHYSICIAN OFFICE NOTIFIED OF APPOINTMENT** □ **PATIENT/FAMILY NOTIFIED OF APPOINTMENT**

FOR SPECIALTY CLINIC USE ONLY **Schedule for** _____**Clinic** **Entered by:** _____
Date: _____

Patient Contact Attempts:
1st Contact Date: _____ **Notes:** _____
2nd Contact Date: _____ **Notes:** _____
3rd Contact Date: _____ **Notes:** _____

☐ **EKG** ☐ **ECHO** ☐ **HOLTER** ☐ **OTHER** _____
☐ **CXR** ☐ **STRESS TEST** ☐ **LABS**

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