MICHIGAN STATE UNIVERSITY HEALTHTEAM

MSU MEDICINE SUB-SPECIALTIES CARDIO-METABOLIC CENTER REFERRAL FORM
Division of Cardiology & Division of Endocrinology, Diabetes and Metabolism
804 Service Road Suite A205, East Lansing, MI 48824
Phone: 517-353-4960; Fax: 517-355-2134

REQUEST FOR CONSULTATION

Referring Physician Name: _____

Referring Physician Signature (required): _____

Office phone number: _____ Office fax number: _____

Patient's name: _____ new patient / previous patient

Male / Female Date of Birth: _____ SSN: _____

Address: _____ City: _____ Zip: _____

Home phone: _____Work Phone: _____ Cell Phone: _____

Diagnosis/Reason for referral: _____

ICD-10 Diagnosis Code (**required for prior to scheduling**): _____

Type of Insurance: _____

REFERRAL TO CARDIOLOGY:

☐ George Abela MD

REFERRAL TO ENDOCRINOLOGY: _____ First Available

☐ Saleh Aldasouqi MD ☐ G Matthew Hebdon MD ☐ Naveen Kakumanu MD

Are there any current test results available? YES _____ NO _____

If yes, please fax all test results (i.e. labs, imaging, etc.) and progress notes pertaining to the consultation. Effective October 1, 2015, insurance prior authorization and ICD-10 codes are required before we are able to schedule patient.

Appointment date and time: _____

Physician scheduled with: _____

We will fax back the appointment information to you. The patient has been informed of this appointment information by mail. Please notify your patient by phone. The patient will receive a new patient packet 2 weeks prior to their appointment date and a reminder call 2 business days prior. Thank you for your referral.