Dr. Stacy Frye, MD FAAP
7237 Fenton Road
Grand Blanc, MI 48439
Phone: (810) 223-0500
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REFERRAL TO: ☑ **DR. STACY FRYE - PEDIATRIC ORTHOPEDICS & SPORTS MEDICINE**

Date of Request: _____ Office contact name: _____ Direct phone: _____

PATIENT INFORMATION (PRINT): Last name: _____ First name: _____

Sex assigned at birth (for medical purposes): M - F - Intersex Pronouns: He/Him She/Her They/Them

Address: _____ City: _____ Zip: _____

DOB: _____/_____/_____ Phone: _____

Parent(s)/Guardian name(s): _____

Parent/Guardian Email: _____

Interpreter needed? _____ No _____ Yes, language: _____

Type of insurance: _____ Authorization number: _____

Contract number:_____ Subscriber name: _____

REFERRING PROVIDER INFORMATION:

Name: _____ NPI number: _____

Address: _____ City: _____ Zip: _____

Office phone: _____ Office fax: _____

REASON FOR REQUEST: Federal guidelines require your request to clearly indicate if this is a CONSULT versus a REFERRAL. Specify if your intent is for a CONSULT (Dr. Frye will evaluate and recommend treatment) OR a REFERRAL (Dr. Frye will evaluate and assume the care of the child for a specific condition).

☐ Request for consultation only.

☑ **REFERRAL for evaluation and care of for the following (signs/symptoms):** _____

_____

IN ORDER FOR THE NEW APPOINTMENT REQUEST TO BE COMPLETED AS QUICKLY AS POSSIBLE, PLEASE SEND:

- Applicable clinic notes
- Imaging and lab result reports
- Copy of insurance card or clinic demographics sheet
- Prior authorization for appointment (if needed)

IMAGING RESULTS MUST BE SENT TO DR. FRYE. PATIENT SHOULD BRING DISC/QR CODE WITH THEM.
We do not have online access to imaging studies or reports at outside facilities.

THANK YOU FOR YOUR APPOINTMENT REQUEST!