REFERRAL FORM

www.Straith.org

Thank you for choosing to refer your patient to our specialists. To begin the referral process, please complete the form and fax to the specialist of your choice below. We will reach out to the patient to schedule an appointment within

Needed For Pain Referrals: Office Notes, Imaging, Medical History, PT History, Medication List

Patient Information

Patient's (legal) name *Last* *First* *MI*	DOB		
Patient's Address	City	State	Zip code
Patient's primary phone	Secondary phone		

Preferred Contact Method? ☐ Early Morning ☐ Mid-Morning ☐ Afternoon ☐ Evening ☐ Anytime

Name of Insurance *Primary* *Secondary*

Referral Information

Referring Provider	Referring Provider phone

Reason for Consultation

☐ General Consultation ☐ Procedure/Surgical Consultation ☐ Medication Management ☐ Other _____

Body Part Affected

☐ Head/Neck ☐ Shoulder ☐ Elbow ☐ Hand/Wrist ☐ Back ☐ Hip ☐ Knee ☐ Foot/Ankle ☐ _____

Diagnosis(ICD-10) or Symptoms

Appointment Time Frame

☐ Urgent (24-48 hours) ☐ Within _____ Weeks ☐ Nonurgent ☐ Other:_____

Physician Specified/ Requested

☐ **Michael Fleischman, DO** ☐ First Available ☐ Michael Drelles, DO ☐ Inpatient Rehabilitation

☐

Please Send Completed Form To The Department Of Your Choice Below

Michael Fleischman, DO
Straith Orthopedics
Joint Pain/Hip/Knee/Shoulder
Phone: 248-386-7278
Fax: 248-386-7286

Michael Drelles, DO
Straith Pain Medicine
Phone:248-386-7267
Fax: 248-386-7269
UP TO A 5 DAY APPROVAL PERIOD

Inpatient Rehabilitation
Allscripts Referrals Preferred
Direct Referrals Accepted
No 3-day Qualifying Stay Req.
Phone: 248-357-3360 Ext: 126

CLEAR FORM