



## SPECIALTY CLINIC REFERRAL FORM

Patient Name: \_\_\_\_\_ Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Request: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Cardiology** | *Nicholas Hoeve, DO, FACC & Jennifer Casey, NP-C*

**ENT** | *Mark Cardamone-Rayner, MD, FACS & Sarah Unger, FNP-C*

**General Surgery** | *Gregory Bambach, MD, FACS*

**GERD & Hiatal Hernia Repair** | *Medhat Fanous, MD, FACS*

**Gynecology & Obstetrics** | *Holly Johnson, NP-C*

**Interventional Radiology** | *Niksa Vlastic, MD*

**Nephrology** | *Suzette Reilley, FNP-C*

**Oncology** | *Green Bay Oncology*

**Orthopedics** | *Cynthia Rubert, MD, FAAOS & Joshua Hood, PA-C*

**Pediatrics** | *James Robertson, MD*

**Podiatry** | *John Niemela, DPM, FACFAS*

**Rheumatology** | *Arthritis Physicians, LLC*

**Sleep Medicine** | *John A Sand, DO, ABSM, FAAFP & Sarah Unger, FNP-C*

**Urology** | *Shahar Madjar, MD & Andrew Anderson, FNP-BC*

**Wound Care** | *Jessica Rochefort, DNP, NP-C, CWCN*

Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred By: \_\_\_\_\_ Referring Office Physician: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Reason for Referral/Chief Complaint (please include dx codes): \_\_\_\_\_

\_\_\_\_\_  
Fax relevant office notes, imaging, and lab results with this referral form

Please fax this request to the Specialty Clinic: **906-341-3299**

Specialty Clinic Referral Coordinator: **906-341-3200 ext 3792 or 3435**