Marshfield Clinic Health System

Bardet-Biedl Syndrome Referral Questionnaire

Requesting provider _____ Self/Family request _____

Full name (first, middle, last) _____ Age _____

Date of birth (DOB) _____ Gender: ☐ Female ☐ Male

Address _____

City _____ State _____ ZIP code _____

Telephone number: Home _____ Cell _____

Other _____

E-mail address _____

Family Information

Mother's name (first, middle, last) _____ DOB _____

Address _____

Father's name (first, middle, last) _____ DOB _____

Address _____

Legal guardian's name, if applicable (first, middle, last) _____

Primary insurance name _____

Insurance policy no. _____ Subscriber no. _____

Telephone number _____

Secondary insurance name _____

Insurance policy no. _____ Subscriber no. _____

Telephone number _____

Medical Assistance: State _____ Type _____

Insurance policy no. _____ Subscriber no. _____

Telephone number _____

Primary care provider name _____

Address _____

Office telephone number _____ Fax number _____

Specific concerns/issues you want evaluated at Bardet-Biedl Syndrome Clinic _____

_____

_____

For more information about Marshfield Clinic Health System's Bardet-Biedl Syndrome Clinic, please call 715-389-3235.

Send your completed questionnaire to Marshfield Clinic Health System, BBS Clinic Coordinator, GR3, 1000 North Oak Avenue, Marshfield, WI 54449-5777. Or you can fax it to 715-387-5240.