

DMC
Sinai-Grace
Hospital

always there.

OFFICE OF MEDICAL AFFAIRS
6071 W. Outer Drive
Phone: (313) 966-3224 ~ Fax: (313) 966-3534

PAR-PHYSICIAN ASSIGNMENT REGISTRAR

Physician Name: _____
(PLEASE PRINT)

For the purpose of ensuring that your patients receive the exceptional quality care that we deliver at Sinai-Grace Hospital, we need the following information to communicate to our care delivery team. When my patient is admitted to the hospital, I prefer that he/she be admitted under:

(PLEASE CHECK THE APPROPRIATE BOX)

Private Physician (must be DMC credentialed)

Name: _____
(PLEASE PRINT FULL NAME)

Hospitalists Name: AIMS

Myself

* I do not wish to be contacted when my patients are admitted.
Please use the admitting physician preference listed above.

Please indicate, in order of preference, all contact numbers that you prefer our staff to use to reach you for patient-care related matters (for example, to contact you when your patient requires admission from the Emergency Department). These numbers will be listed in our physician's database for access to our Sinai-Grace Hospital staff ONLY:

* Contact Preference #1 _____ Pager Cell Office

* Contact Preference #2 _____ Pager Cell Office

* Contact Preference #3 _____ Pager Cell Office

Signature: X _____ Date: X _____

Changes and updates to this information can only be made through the Medical Affairs Office at Sinai-Grace Hospital contact Darlene McGee – Medical Staff Coordinator.

Forms are available in the Sinai-Grace Office of Medical Affairs, located on the first floor.

Date: _____


This is to advise St. Mary Mercy Hospital that my patients presenting to the Emergency Department requiring admission are to be admitted to the service of:

(Your current admitter is _____)

Admitting Physician: AIMS

The above physician has admitting privileges at St. Mary Mercy Hospital

Authorization from:

Physician Name <u>(Please PRINT first and last)</u> Degree Specialty Male <input type="checkbox"/> Female <input type="checkbox"/>	
Address: City & Zip	
Office Phone Fax #	
Authorizing Physician signature (sign please)	

**PLEASE FAX COMPLETED FORM TO:
SMMH Medical Staff Office at 734.655.1445 – Thank you**

Beaumont

EC Physician Preference Guide

Last Name

First Name

To render care to your patients in an efficient, effective, and meaningful fashion, while recognizing our mutual desire to honor your requests, please complete this form. **Please type or print.**

Name: _____ Home: _____
Address: _____ Office Phone: _____
_____ Answering Service: _____
Specialty: _____ Pager Number: _____

My admission preference when my patient arrives in the Department of Emergency Medicine is as follows (check one only per facility):

ROYAL OAK BEAUMONT:

I admit my own patients (The emergency department will ALWAYS call you if we are admitting a patient to you.)

I refer all inpatient admission to: AIMS (Academic Internal medicine Specialists)

Yes, please give me a courtesy call.

TROY BEAUMONT:

I admit my own patients (The emergency department will ALWAYS call you if we are admitting a patient to you.)

I refer all inpatient admission to: _____

Yes, please give me a courtesy call.

GROSSE POINTE BEAUMONT:

I admit my own patients (The emergency department will ALWAYS call you if we are admitting a patient to you.)

I refer all inpatient admission to: _____

Yes, please give me a courtesy call.

If you cannot reach me in a reasonable amount of time (about 30 minutes), you may go ahead and refer the patient as follows.

(Insert a name for each specialty-& specify which facility):

- | | |
|----------------------------------|--|
| 1. Allergy-Immunology: _____ | 16. Neurosurgery: _____ |
| 2. Cardiovascular Disease: _____ | 17. Obstetrics/Gynecology: _____ |
| 3. Cardiac Surgery: _____ | 18. Ophthalmology: _____ |
| 4. Colon / Rectal Surgery: _____ | 19. Oral Surgery: _____ |
| 5. Endocrinology: _____ | 20. Orthopedics: _____ |
| 6. Gastroenterology: _____ | 21. Otolaryngology: _____ |
| 7. General Surgery: _____ | 22. Pediatric Specialists: _____ |
| 8. Geriatric Medicine: _____ | 23. Pediatric Surgery: _____ |
| 9. Hand Surgery: _____ | 24. Peripheral Vascular Surgery: _____ |
| 10. Hematology/Oncology: _____ | 25. Plastic Surgery: _____ |
| 11. Infectious Disease: _____ | 26. Psychiatry: _____ |
| 12. Internal Medicine: _____ | 27. Pulmonary Medicine: _____ |
| 13. Medicine/Pediatrics: _____ | 28. Rheumatology: _____ |
| 14. Nephrology: _____ | 29. Thoracic Surgery: _____ |
| 15. Neurology: _____ | 30. Urology: _____ |

Signature: _____ Date: _____

Please return form to:

Beaumont Health System
Credentialing and Assessment Services/ATTN: Lindsey Piontkowski
130 Town Center Dr. #203, Troy, MI 48084 248-585-8222 (phone) 248-585-8270 (fax)

Note: Entries and changes may be made online at any time by accessing dr.beaumont.edu and clicking the EC Physician Preference Guide link.



HENRY FORD
MACOMB HOSPITALS

Designation of Admissions and Preferred Inpatient Consultants Henry Ford Macomb Hospital, Clinton Township

Physician Information (PLEASE PRINT)

Name: _____ Practice Name: _____

Practice Address: _____

Practice Phone: _____ Practice Fax: _____

Physician's E-mail Address: _____

Cell Phone: _____ Pager: _____

Office Contact Person: _____ Contact Phone: _____

Contact Person's E-mail Address: _____

- Patients who identify me as their primary care physician should be admitted to:
 - ___ Myself
 - AIMS
 - ___ Great Lakes Medicine
 - ___ Sterling Internal Medicine
- Contact you on Admission? ___ YES ___ NO

Please name only one person by first and last name, or only one Group Practice Name

<u>SPECIALTY</u>	<u>One Name only</u>
Cardiology	
- General	_____
- Interventional	_____
- EP	_____
- Cardiothoracic	_____
Dermatology	_____
Endocrinology	_____
ENT	_____
Gastroenterology	_____
GYN	_____
Hem/Onc	_____
Infectious Disease	_____
Nephrology	_____
Neurology	_____
OB/GYN	_____
Ophthalmology	_____

Please name only one person by first and last name, or only one Group Practice Name

<u>SPECIALTY</u>	<u>One Name only</u>
Orthopedics	_____
Pediatrics	_____
PM&R	_____
Psychiatry	_____
Pulmonary	_____
Rheumatology	_____
Surgery, Colorectal	_____
Surgery, General	_____
Surgery, Hand	_____
Surgery, Neurological	_____
Surgery, Plastic	_____
Surgery, Podiatric	_____
Surgery, Spine	_____
Surgery, Thoracic	_____
Surgery, Vascular	_____
Surgery, Urology	_____
Other	_____

Physician Signature

Date

FAX COMPLETED FORM TO PHYSICIAN SUPPORT SERVICES (586) 263-2868

Beaumont

Physician Information Update for Inpatient Admissions or Observation Placements
through the Emergency Departments for Dearborn, Taylor, Trenton and Wayne Only

PLEASE PRINT

Physician Name: _____

Group Practice or Group Affiliation Name: _____

Address: _____

Office Phone: () _____ Office Fax: () _____

If your patient is admitted to any of the following hospitals....

(please check only one box per site)

Wayne: Admit to Self
 Admit to Med Staff On Call

(admit to this designated alternate provider)

Dearborn: Admit to Self
 Admit to Med Staff On Call

(admit to this designated alternate provider)

Dearborn Observation Unit:

Admit to Self (Must be a member of IMA)
 Admit to Med Staff On Call

(admit to this designated alternate provider)

Taylor: Admit to Self
 Admit to Med Staff On Call

(admit to this designated alternate provider)

Trenton: Admit to Self
 Admit to Med Staff On Call

(admit to this designated alternate provider)

*Once this initial form has been submitted, Physicians are responsible for notifying the physician liaisons
of any changes or updates to this profile.*

Physician Signature: _____ Date: _____

Please fax or scan and email the completed form to only one physician liaison listed below:

Dearborn: Dan Cytacki
Phone: 248-632-3582
Daniel.Cytacki@beaumont.org
Fax: 313-436-2042

Dearborn: Freda Smith
Phone: 313-593-7084
Freda.Smith@beaumont.org
Fax: 313-436-2042

Taylor: Amy Lavrack
Phone: 313-375-7084
Amy.Lavrack@beaumont.org
Fax: 313-295-5085

Trenton: Debbie Beaudrie
Phone: 734-671-3903
Deborah.Beaudrie@beaumont.org
Fax: 734-671-3323

Wayne: Jane Dause
Phone: 734-467-2524
Jane.Dause@beaumont.org
Fax: 734-467-4017