Dear Colleague:

Thank you for referring your patient to the University of Michigan Health System’s Department of Neurosurgery. We value our relationship with you and appreciate your confidence in our service and staff.

It is our goal to provide your patient with the highest quality of care in the most efficient manner. To expedite the referral process, we would appreciate your assistance in completing the attached referral request form and faxing it, along with the following information, to 734/647-9233:

**Office Notes**  (related to Neurosurgery diagnosis)

**Diagnostic Reports**  (MRI and CT within the last 6 months, other Radiology reports no more than 1 year)

**All films should be hand carried by the patient to their clinic appointment.**

We will contact your office to confirm receipt and to notify you of the appointment time offered to your patient. In addition, you may be contacted to provide additional information or additional diagnostic studies that would be helpful in treating your patient. This process may take between 2 to 5 working days. Once the appointment has been scheduled, we will mail an appointment notice to the patient.

The Adult Neurosurgery Service can be reached via M-LINE at 1-800-962-3555. Ask to be connected to our nurse practitioners, to the adult neurosurgeon on-call, or to a specific surgeon. Calls outside of business hours are referred initially to the neurosurgery resident on call.

Again, we greatly appreciate your confidence in referring your patient to our service.

Cordially,

Karin M. Muraszko, M.D.
Professor and Chair
Department of Neurosurgery
# Outpatient Consult Request

**To**
- **Referred to:**
  - (Specialty Clinic or Service)
  - **Physician Name / Location:**
    - (Optional)

**From**
- **Referring Physician:**
  - __________________________
  - **Office Name:**
    - (Please Print)
  - **Office Contact:**
    - ________________________
    - **Phone#:** (____)____________________
  - **Fax#:** (____)____________________
  - **E-Mail Address:**
    - ________________________

**PCP**
- *(If different from Referring)*
  - **Physician Name:**
    - __________________________
    - **Office Name:**
      - (Please Print)
  - **Office Contact:**
    - ________________________
    - **Phone#:** (____)____________________
  - **Fax#:** (____)____________________
  - **E-Mail Address:**
    - ________________________

**Patient Information**
- **Name:**
  - **Last** ____________________
  - **First** ____________________
- **UMHS Registration #** *(if available):* __________________
- **Gender:** □ M □ F
- **DOB:** ______________________
- **Telephone:**
  - Home (____)________________
  - Work (____)________________
  - Other (____)________________
- **Address:** __________________
  - **City:** __________________
  - **State:** ________
  - **Zip:** ________

**Other Contact Information** *(if applicable)*
- **Mother’s Name:**
  - __________________________
  - **Father’s Name:**
    - __________________________
  - **Telephone:**
    - Home (____)________________
    - Work (____)________________
    - Other (____)________________

**Insurance Information**
- **Insurance:**
  - □ HMO □ PPO □ POS □ Traditional □ Medicare □ None
  - **Medicaid:** □ HMO □ Other
  - **Medicaid Insurance Plan:** __________________________
- **Auto Accident:** □ Y □ N
  - **Date of Injury:** ________
  - **Work Comp:** □ Y □ N
  - **Date of Injury:** ________

**UMHS Consult Request Guidelines**
- [www.med.umich.edu/umconsults](http://www.med.umich.edu/umconsults)

**Diagnosis and Reason for Consult or Therapy**
- **Physician Signature:** *(Required for PT and diagnostic tests only)*
  - **(Signature)**
  - **(Date)**

**Appointment Requested:**
- □ Next Available
- □ Within 2 weeks
- □ Within 1 week
- □ Other __________________

**Second Opinion?** □ Yes □ No

**Questions? Contact M-LINE at 800-962-3555**

*Fax completed form directly to the clinic fax number provided or to M-LINE at 734-615-5886*