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Dear Colleague:

Thank you for referring your patient to Pediatric Neurosurgery at the University of Michigan. 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 734/615-3722:

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

Once the fax is received, we will contact your office within two business days 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.

The Pediatric Neurosurgery Service can be reached via M-LINE at 1-800-962-3555. Ask to be connected to our offices, to the pediatric neurosurgeon on-call, or to a specific surgeon (Dr. Muraszko, Dr. Garton, Dr. Maher).

Office voicemail is checked frequently and calls are returned within one hour during normal business hours. Calls outside of business hours are referred 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

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

To	Referred to: _____ <small>(Specialty Clinic or Service)</small> Physician Name / Location _____ <small>(Optional)</small>	
From	Referring Physician: _____ Office Name: _____ <small>(Please Print)</small> Office Contact: _____ Phone#: (____) _____ Fax#: (____) _____ E-Mail Address: _____	
PCP <small>(If different from Referring)</small>	Physician Name: _____ Office Name: _____ <small>(Please Print)</small> Office Contact: _____ Phone#: (____) _____ Fax#: (____) _____ E-Mail Address: _____	
Patient Information	Name: Last _____ First _____ <small>(Please Print) (Please Print)</small> UMHS Registration # (if available): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F DOB: _____ Telephone: Home (____) _____ Work: (____) _____ Other: (____) _____ Address: _____ City: _____ State: _____ Zip: _____	
Other Contact Information <small>(if applicable)</small>	Mother's Name: _____ Father's Name: _____ Other (please explain): _____ Telephone: Home(____) _____ Work: (____) _____ Other: (____) _____	
Insurance Information	Insurance: _____ <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Traditional <input type="checkbox"/> Medicare <input type="checkbox"/> None Medicaid: <input type="checkbox"/> HMO <input type="checkbox"/> Other Medicaid Insurance Plan: _____ Auto Accident? <input type="checkbox"/> Y <input type="checkbox"/> N Date of Injury _____ Work Comp? <input type="checkbox"/> Y <input type="checkbox"/> N Date of Injury _____	
Diagnosis and Reason for Consult or Therapy	<u>UMHS Consult Request Guidelines</u> www.med.umich.edu/umconsults	Appointment Requested: <input type="checkbox"/> Next Available <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 1 week <input type="checkbox"/> Other _____ Second Opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No
Requesting Physician	Physician Signature: (Required for PT and diagnostic tests only) _____ <small>(Signature) (Date)</small>	