REQUEST FOR CONSULTATION AND/OR TESTING AT THE MICHIGAN EAR INSTITUTE

Attn: Appointment Dept. - Phone 248-865-4444 Fax 248-865-6161

Date:_____

Patient Legal Name:_____

Address:_____

Phone:_____ Date of Birth:_____

Referring Physician: _____

Address: _____

Phone:_____ Fax: _____

****Please fax demographics and medical records on the patient you are referring.****

___PATIENT will contact MEI to make an appointment at 248-865-4444, Option #2, then #1.
___MEI is to contact the patient to make the appointment.
___MEI is to contact the referring doctor to make appointment. Attn:_____

Reason for referral:_____

_____

****Note: If you have an HMO this form is not an insurance authorization. Please contact your Primary Care Physician for that.**

Your patient is scheduled with _____

At on_____ @_____ am/pm.

Visit our website at www.michiganear.com for new patient forms to be filled out.
THANK YOU FOR YOUR REFERRAL TO THE MICHIGAN EAR INSTITUTE

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REV June 8th, 2020