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**
☐**MEI is to contact the patient to make the appointmet at** _____
☐**MEI is to contact the referring doctor to make appointment at** _____

Reason for referral:_____

**** Note: If you have an HMO this form is not an insurance authorization. Please contact our 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

Dennis I. Bojrab, M.D.	**Seilesh C. Babu, M.D.**	**John J. Zappia, M.D.**
Eric W. Sargent, M.D.	**Eleanor Y. Chan, M.D.**	**Robert S. Hong, M.D.**
Ilka C. Naumann, M.D.	**Candice C. Colby, M.D.**	**Christopher A. Schutt, M.D.**