

**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 appointment 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 your Primary Care Physician for that.**

**Your patient is scheduled with** \_\_\_\_\_

**At** \_\_\_\_\_ **on** \_\_\_\_\_ **@** \_\_\_\_\_ **am/pm.**

**Visit our website at [www.michiganear.com](http://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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