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Department of Neurosurgery

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Dear Colleague:

Thank you for referring your patient to the University of Michigan Hospitals & 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 must be within the last 6 months, other Radiology reports no more than 1 year). If current images and prior to the 6 months scans are available via CD, please send the CD to:

Referral Office
Department of Neurosurgery
1500 E. Medical Center Dr., 3470 TC
Ann Arbor, MI 48109-5338

All non-electronic films (films viewed by view boxes) 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 Pediatric Neurosurgery Office can be reached by calling 734-615-0536. Adult Neurosurgery Referral Office can be reached by calling 734-936-7010. Calls outside of business hours are referred initially to the neurosurgery resident on call, please call 734-936-6267 and ask that the resident on call be paged.

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

University of Michigan Health System

Outpatient Consult Request Form

Department of Neurosurgery

Phone: 734-936-7010 Fax: 734-647-9233

TO:	**Referred to:** _____ **Physician Name / Location:** _____ (Optional)
FROM:	**Referring Physician:** _____ **Office Name:** _____ **Contact Person:** _____ **Phone:** _____ **Fax:** _____
PCP (if different from Referring Physician)	**Referring Physician:** _____ **Office Name:** _____ **Contact Person:** _____ **Phone:** _____ **Fax:** _____
Patient Information	**Last Name**: _____ **First Name**: _____ **UMHS Registration #:** _____ **Gender:** ☐ M ☐ F DOB: _____ **Home Ph:** _____ **Work:** _____ **Other:** _____ **Address:** _____ **City:** _____ **State:** ____ **Zip:** _____
Other Contact Information (if applicable)	**Mother's Name:** _____ **Father's Name:** _____ **Other (please explain):** _____ **Home Ph:** _____ **Work:** _____ **Other:** _____
Insurance Information	**Insurance:** _____ **Contract/Group #:** _____ **Medicaid** ☐ HMO ☐ PPO ☐ Other ☐ **Auto Accident? Workmans Comp** ☐ **Y** ☐ **N** **Injury Date:** _____
Diagnosis & Reason for Consult or Therapy	Please send office notes & radiology reports related to Neurosurgery Diagnosis Appointment Requested: ☐ Urgent ☐ Routine Second Opinion? ☐
Requesting Physician	**Pnysician Signature:** (required for PT and diagnostic tests only) _____ Signature Date