Consult Request Form

Huron Valley Neurology

24 Frank Lloyd Wright Dr
P O Box 444
Lobby L, Suite 2300
Ann Arbor, MI 48106
Fax: 734-930-5630 Phone: 734-930-5300

Referring Physician Information

Name	
Phone	Fax
Physician Signature	

Patient Information:

Name			Sex Male Female
Address			
City	State	ZIP	Date of Birth
Home Telephone	Parent's name (if minor)		
Alternate Contact Name		Telephone Number	

Insurance Information:

Insurance Company Name		Effective Date
Name of Policy Holder		
Policy Holder's SSN	Policy Holder's D.O.B	
Policy #	Group #	Is this an HMO POS PPO

Reason for Consultation:

Testing Only ☐

Testing requested: ☐ EEG EMG ☐ Upper Extremities ☐ Lower Extremities ☐ Vestibular Testing

IMPORTANT: When faxing this request, please also send physicians notes related to the consultation (if possible a summary by physician of the above problem), MRI/CT/EEG reports and any other information you feel that would be important for us to know.

Thank you for referring your patient to Huron Valley Neurology.

Brian Woodruff, M.D *Olav Jaren, M.D., Ph.D.*