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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