

Thank you for your Referral to Marquette General Neurology
We are located at Marquette General Hospital on the 3rd Floor Skywalk

CONSULT Request Form

Date of Request: ___ / ___ / ___

Referring Physician's Name: _____ NPI# _____

Referring Physician's phone # _____ Office Fax # _____

Referring Physician Signature _____

Patient First Name: _____ MI: _____ Last Name: _____

Date of Birth: ___ / ___ / ___ SS# _____ - _____ - _____

Address: _____

Phone (H): _____ (W) _____

Insurance Info: _____ Policy # _____

Symptoms: _____

Suspected Condition: _____

Testing:

Please complete the checklist to let us know if Any testing has been done.

***Please fax office visit notes related to this referral along with all test results, this form and medication list.**

- | Yes | No | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | EEG |
| <input type="checkbox"/> | <input type="checkbox"/> | MRI/CT* |
| <input type="checkbox"/> | <input type="checkbox"/> | Labs |
| <input type="checkbox"/> | <input type="checkbox"/> | EMG |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Study |
| <input type="checkbox"/> | <input type="checkbox"/> | ER or hospital notes |

— INTERNAL USE ONLY—

Scheduled with: _____

Appointment Date _____

Additional Info. needed: _____

**Please have patient bring films or CD if MRI/CT not done at MGH.
Have patient bring insurance/billing information**

*****PLEASE FAX THIS FORM AND RECORDS TO: 906-225-4589*****