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## REFERRAL FORM

**Today's Date** \_\_\_ / \_\_\_ / \_\_\_

**Patient Information:** (only completed forms will be accepted)

Patient Name \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #1 ( \_\_\_ - \_\_\_ ) \_\_\_ - \_\_\_ - \_\_\_ Phone #2 ( \_\_\_ - \_\_\_ ) \_\_\_ - \_\_\_ - \_\_\_

**Insurance:**

Primary \_\_\_\_\_ ID# \_\_\_\_\_ Group \_\_\_\_\_

Secondary \_\_\_\_\_ ID# \_\_\_\_\_ Group \_\_\_\_\_

\_\_\_ Auto DOI \_\_\_ / \_\_\_ / \_\_\_ \_\_\_ Worker's Compensation DOI \_\_\_ / \_\_\_ / \_\_\_

Is this office visit related to an injury? \_\_\_ yes \_\_\_ no Place of occurrence \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_ Claim # \_\_\_\_\_

Adjuster name \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have an attorney? \_\_\_ yes \_\_\_ no

If yes, Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Reason for Referral:** \_\_\_\_\_

\_\_\_ Consultation/Treat \_\_\_ Evaluation/Treat \_\_\_ EMG/NCS

**Studies Completed:** \_\_\_ X-rays \_\_\_ MRI \_\_\_ CT Scan \_\_\_ EMG \_\_\_ None

**\*\* Please Send Chart Notes & Imaging Studies (if not done at SJMH) with Referral \*\***

- |                            |                      |  |   |
|----------------------------|----------------------|--|---|
| ___ <b>First Available</b> | ___ <b>Preferred</b> | <input type="checkbox"/> Adil Ali, MD          | <input type="checkbox"/> Paul Shapiro, MD       |
|                            |                      | <input type="checkbox"/> Jennifer E. Doble, MD | <input type="checkbox"/> David P. Steinberg, MD |
|                            |                      | <input type="checkbox"/> Steven N. Gross, DO   | <input type="checkbox"/> Marc L. Strickler, MD  |
|                            |                      | <input type="checkbox"/> Steven C. Harwood, MD | <input type="checkbox"/> Jon M. Wardner, MD     |
|                            |                      | <input type="checkbox"/> Owen Z. Perlman, MD   | <input type="checkbox"/> Mala Young, MD         |
|                            |                      | <input type="checkbox"/> Ari Kriswari, MD      |   |

**Location:** \_\_\_ Ypsilanti \_\_\_ Canton (Ali, Gross, Harwood) \_\_\_ Brighton (Doble, Young, Strickler, Wardner)

**Scheduling Priority:** \_\_\_ Urgent (1-3 days) \_\_\_ Expedited (4-10 days) \_\_\_ Routine (2 weeks)

**Referring Physician:** \_\_\_\_\_

**Contact Person** \_\_\_\_\_

**Phone** ( \_\_\_ - \_\_\_ ) \_\_\_ - \_\_\_ - \_\_\_ **Fax** ( \_\_\_ - \_\_\_ ) \_\_\_ - \_\_\_ - \_\_\_