McLaren

THUMB REGION

McLaren Thumb Neurology Clinic

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REQUEST FOR CONSULTATION

_____ Consult/Advise Only _____ Consult/Co-Manage Care w PCP

_____ EMG/NCS Only _____ EMG/NCS Consultation

For EMG's please circle what is needed

BIL upper extremities Rt. Upper extremity Lt. Upper extremity BIL Lower Extremities Rt. Lower extremity Lt. Lower Extremity Or both Upper and Lower extremities

The referring physician must complete all of the necessary testing to support the referring diagnosis and that testing must be received by our office before an appointment will be scheduled

MUST HAVE INFO

DEMOGRAPHICS & INSURANCE CARDS, CURRENT OFFICE NOTE pertaining to referral need, MED LIST with dosing information, MEDICAL/SURGICAL/SOCIAL HISTORIES, DIAGNOSTIC TESTING pertaining to referral dx, (Lab,MRI,EEG,CT,Carotid,EMG)

Requesting Physician

Name _____

Address _____ City _____ State _____ Zip _____

Office Phone _____ Office Fax _____

Patient Information

Diagnosis _____

Remember to complete the appropriate testing to support your diagnosis

Name: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Social Security # _____ Date of Birth _____

Insurance Information

Insurance Company _____

Policy# _____ Group# _____

Authorization # _____

Be sure to attach global authorizations when necessary

Auto _____ Work Comp _____

Attach Open Letter or Authorization from Payer