METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

Request for Treatment

Infectious Disease | Neurology | Epilepsy | Neurointerventional Radiology

WE CANNOT REVIEW OR SCHEDULE A REFERRAL IF WE DO NOT HAVE THIS FORM COMPLETED AND ALL NECESSARY RECORDS.
Records must be sent if you do not have access to Metro Health Epic Ambulatory. We will need all radiology reports relating to diagnosis (including discs of images if done at non-Metro Health facility), recent lab work, nerve testing, EMGs, and all specialty records if patient has already seen another specialist.

All lines with an asterisk (*) MUST be filled out.

What specialty are you referring to?

☐ Infectious Disease ☐ Neurology ☐ Epilepsy ☐ Neurointerventional Radiology ☐ Neurosurgery

What specialist would you like your patient to be scheduled with?

☐ Dr. Ehrhardt (neuro) ☐ Dr. Swartz (epilepsy) ☐ Dr. Siddiqui (neuro IR) ☐ Dr. Sagher (neurosurgery)
☐ Dr. Taylor (neuro) ☐ Dr. Amaresh (neuro IR) ☐ Dr. DeHart (I.D.) ☐ No Preference
☐ Dr. Wasielewski (neuro) ☐ Dr. Elias (neuro IR) ☐ Dr. El Mortada (I.D.)

FIELDS MARKED WITH AN ASTERISK (*) ARE REQUIRED

*Last Name ______ *First Name ______ Middle Initial: ______

Sex: ☐ M ☐ F ______ *DOB: ______ SS# ______

*Address ______ City ______ Zip ______

*Preferred Phone Number (   ) ______ Alternate Phone Number (   ) ______

*Emergency Contact: ______ Relationship: ______ Phone: (   ) ______

*Insurance: ______ *Contract # ______ *Group # ______

If patient is under 18 or not their own guardian:

*Legal guardian name: ______ Phone: (   ) ______ DOB: ______

Please include a copy of BOTH sides of insurance card

*Referring Physician: ______ PCP (if not referring physician): ______

*Phone Number: (   ) ______ Phone Number: (   ) ______

*Fax: (   ) ______ Fax: (   ) ______

*Office Contact: ______ Office Contact: ______

***Diagnosis** ______ *** ICD-10** ______

*Is this a second opinion? ☐ Yes ☐ No If yes, who did patient see previously? (We will need all records from this)

______

*Does the patient need an interpreter? ☐ Yes ☐ No If yes, what language? ______

*Medication Allergies: ______

---------- **FOR METRO HEALTH USE ONLY BELOW THIS LINE** ----------

Appointment Information

Date ______ Time ______ ☐ AM ☐ PM

with ______ Patient informed by Metro Health? ☐ Yes ☐ No

METRO HEALTH PHYSICIAN SPECIALTY OFFICES

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