University of Michigan Health System

Outpatient Consult Request

Please fax completed form to 734/647-9233

To

Referred to: Brachial Plexus/Peripheral Nerve Program (734/936-5017)
(Specialty Clinic or Service)

Physician Name / Location _____
(Optional)

From

Referring Physician: _____ (Please Print) Office Name: _____

Office Contact: _____ Phone#: (___)_____

Fax#: (___)_____ E-Mail Address: _____

PCP (If different from Referring)

Physician Name: _____ (Please Print) Office Name: _____

Office Contact: _____ Phone#: (___)_____

Fax#: (___)_____ E-Mail Address: _____

Patient Information

Name: Last _____ (Please Print) First _____ (Please Print)

UMHS Registration # (if available): _____ Gender: ☐M ☐F DOB: _____

Telephone: Home (___)_____ Work: (___)_____ Other: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

Other Contact Information (if applicable)

Mother's Name: _____ Father's Name: _____

Other (please explain): _____

Telephone: Home(___)_____ Work: (___)_____ Other: (___)_____

Insurance Information

Insurance: _____ ☐ HMO ☐PPO ☐POS ☐Traditional ☐Medicare ☐None

Medicaid: ☐HMO ☐Other Medicaid Insurance Plan: _____

Auto Accident? ☐ Y ☐N Date of Injury _____ Work Comp? ☐Y ☐N Date of Injury _____

Diagnosis and Reason for Consult or Therapy

Peripheral Nerve Trauma? ___Yes ___ Other (Please comment):

Primary reason for Peripheral Nerve Referral:
___Motor Weakness ___Sensory Deficit ___Pain
Other (explain):

Affected limb: ___ Shoulder ___Brachial Plexus ___Upper Extremity
___Lower Extremity ___ Hip/Groin ___Other (explain)

Appointment Requested:
- ☐ Next Available
- ☐ Within 2 weeks
- ☐ Within 1 week
- ☐ Other _____

Second Opinion? ☐Yes ☐No

Onset of injury/Duration of symptoms ___<1 mo ___ 1-3 mo ___ 3-6 mo ___>6 mo ___Other

Targeted provider within interdisciplinary clinic (please check one):
___ Per protocol/unsure ___Neurosurgery ___Pain/Interventional ___Physical Medicine & Rehabilitation
___ Plastic Surgery ___ Electrodiagnostics ___ Other (please comment):

Note that our specialized pain physicians provide recommendations but do NOT provide chronic management of pain medications.

Requesting Physician

Physician Signature: (Required for PT and diagnostic tests only)

_____
(Signature) (Date)