Michigan
Neurosurgical
Institute

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Phone (810) 606-7200
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www.michiganneurosurgicalinstitute.com

Facsimile Cover Letter

Date:

From: MNI, P.C.

Attn:

Phone: (810) 606-7200

Fax: ( ) -

Number of pages (including cover sheet):

Dear Colleague and Staff:

Please use this new intake form when referring new patients to this office. When faxing back, please include copies of patient's current insurance card(s), and any diagnostic reports (CT, MRI, X-ray, EMG, etc.) pertaining to the patient's condition for this referral.
If your office uses an electronic health record system, to expedite your referral process, it is acceptable to include patient's demographic face sheet along with current copies of the insurance card(s) in place of completing section 1 and 2.

Please provide this form to all referring physicians within your practice. Should you have any questions, please feel free to contact our office.

Thank you!

ATTENTION

The documents in this facsimile transmission may contain confidential health information that is privileged and legally protected from disclosures by the Health Insurance Portability and Accountability Act (HIPAA). This information is intended for the use of the individual or entity named below. If you are not the intended recipient, you are hereby notified that reading, dissemination, disclosing, distributing, copying, acting upon or otherwise using the information contained in this facsimile is strictly prohibited. If you have received this information in error, please notify this office immediately and return this original message to our office at the address below via the U.S. Postal Service or allow us to make arrangements to retrieve this transmission at no cost to you.

Michigan Neurosurgical Institute, PC
Avery M. Jackson III, MD, FACS, FAANS
New Patient Intake Form
Phone (810)606-7200 Fax (810)606-7115

Date Received: _____ PLEASE PRINT INFORMATION!

**Please complete Sections 1-4. Fax intake back along with copies of medical reports indicated in Section 3.

SECTION 1 -Patient Demographics (If on an E.H.R, your patient face sheet is acceptable-proceed to Section 2)

First Name: _____ MI: _____ Last Name:_____ DOB: _____

Address: _____ City: _____ Zip: _____

Home #: ( ) _____ Cell #: ( ) _____ Work#: ( ) _____

☐ Preferred Language _____ ☐ Race _____ ☐ Ethnicity _____

SECTION 2 -Patient Insurance Information (Please complete fully & FAX Copy of Current Insurance Cards-proceed to Section 3)

*Primary Insurance Name:
_____

Subscriber: ☐ Self ☐ Spouse: (name) _____ DOB: _____

Insurance Certificate ID: _____ Suffix: _____
(Include relevant prefix)

Group/plan #: _____

Ins Address: _____ Ins Phone#:_____

*Secondary Insurance Name:
_____

Subscriber: ☐ Self ☐ Spouse: (name) _____ DOB: _____

Insurance Certificate ID: _____ Suffix: _____
(Include relevant prefix)

Group/plan #: _____

Ins Address: _____ Ins Phone#:_____

Section 3-Patient Medical Information (Complete Fully-proceed to Section 4)

Pharmacy Name:_____Phone #:_____
Height _____Weight_____

Patient Diagnosis (reason for
Referral):_____

☐ MRI _____ ☐ X-ray _____ ☐ CT _____ ☐ EMG_____
☐ Physical Therapy _____ ☐ Pain Management_____ ☐ ESI injections _____
☐ SI joint_____ ☐ DEXA _____ ☐ Recent Lab Results _____

Has patient seen another Neurosurgeon in the past? If so, list name(s) and any previous history of neurological surgeries:

Neurosurgeon: _____ Date seen: _____

History of sx:_____

Section 4-Referring Physician Information

Ref/PCP affiliation ☐ Genesys PHO ☐ McLaren PHO ☐ other affiliation _____

Referring Phys: _____ PH#:( )_____ Spoke to: _____

PCP:_____ PH#:( )_____ Spoke to:_____

Referring email address: _____