

Thank you for choosing to refer your patient to our specialists. To begin the referral process, please complete the form and fax to the specialist of your choice below. We will reach out to the patient to schedule an appointment!

**Needed For Pain Referrals: Office Notes, Imaging, Medical History, PT History, Medication List**

| Patient Information   |               |                  |                          |           |          |
|---|---------------|------------------|--------------------------|-----------|----------|
| Patient's (legal) name <i>Last</i>  |               | <i>First</i>     |                          | <i>MI</i> | DOB      |
| Patient's Address   |               |                  | City                     | State     | Zip code |
| Patient's primary phone   |               |                  | Secondary phone          |           |          |
| Preferred Contact Method?   | Early Morning | Mid-Morning      | Afternoon                | Evening   | Anytime  |
| Name of Insurance <i>Primary</i>  |               | <i>Secondary</i> |                          |           |          |
| Referral Information  |               |                  |                          |           |          |
| Referring Provider  |               |                  | Referring Provider phone |           |          |
| Reason for Consultation<br>General Consultation    Procedure/Surgical Consultation    Medication Management    Other _____                                    |               |                  |                          |           |          |
| Body Part Affected<br>Head/Neck    Shoulder    Elbow    Hand/Wrist    Back    Hip    Knee    Foot/Ankle _____   |               |                  |                          |           |          |
| Diagnosis(ICD-10) or Symptoms   |               |                  |                          |           |          |
| Appointment Time Frame<br>Urgent (24-48 hours)    Within _____ Weeks    Nonurgent    Other: _____   |               |                  |                          |           |          |
| Physician Specified/ Requested<br>Michael Fleischman, DO    Roland Brandt, DO    Michael Drelles, DO    Nadine Jennings, MD<br>Inpatient Acute Rehabilitation |               |                  |                          |           |          |

**Please Fax Completed Form To The Provider Of Your Choice Below:**

**Please Note: For Referrals To Inpatient Acute Rehabilitation Please Call First at 248.867.9756. Fax Inpatient Rehab Form To 248.357.0915**

Michael Fleischman, DO  
 Orthopedic Surgeon  
 Phone: 248-386-7278  
 Fax: 248-386-7286

Roland Brandt, DO  
 Orthopedic Surgeon  
 Phone: 248-386-7278  
 Fax: 248-386-7286

Michael Drelles, DO  
 Pain Medicine  
 Phone: 248-386-7267  
 Fax: 248-386-7269

Nadine Jennings, MD  
 PM&R  
 Phone: 248-386-7280  
 Fax: 248-386-7290

UP TO A 5 DAY APPROVAL PERIOD