Physician Referral Form

**Fax Referrals to: (317)570-2286**

**Michael H. Levine M.D.**

**• • •**

**Caryn M. Vogel M.D.**

**Indianapolis**

***(Meridian Street)***

**9302 N. Meridian St., Suite 101**

**Indianapolis, IN 46260**

 **Referring Physician Information** Date: Phone: Contact Name:

Referring Provider: Scheduling Coordinator Name: Phone: Referring Provider Fax Number:

#  Patient Information

Patient Name: Phone:

Date of Birth: Policy #: Insurance Company: Type of Policy:

Policy Holder Name (if different from above): Patient Diagnosis:

* **Neurology Consult:**
* **Headache Management Consult:**
* **Sleep Consultation/Home Sleep Study:**
* **EMG Electromyography/Nerve Conduction Velocity:**
	+ RUE  LUE  Bilat Upper Ext  RLE  LLE  Bilat Lower Ext

#  Indiana Neuroscience Associates Contact Information

Please Call Our Referral Coordinator with Any Concerns Regarding the Referral Process

**317-570-7900** • [www.indiananeurologist.com](http://www.indiananeurologist.com/)

#  For Indiana Neuroscience Associates Use Only:

Form Will Be Faxed Back To Referring Physician Once Appointment Is Scheduled

Appointment Date: Time: Physician: Location: