WALLACE-KETTERING Neuroscience Institute
KETTERING HEALTH NETWORK

3533 Southern Blvd, Suite 5200
Kettering, Ohio 45429
Phone (937) 395-8043
Toll Free (844) 211-5482
Fax (937) 395-8139

Request for Consultation

Below sections MUST be completed entirely before we can schedule the patient. Thank you.

CONSULTATION REQUEST FOR: **Neurointervention**	**Today's Date:**
Please indicate reason for consult:	

Patient Name: Last	**First**	**MI**	**Date of Birth:**	**Social Security #:**
Address:	**City:**		**State:**	**Zip:**
Preferred Phone #: (circle Home or Cell)	**Secondary Phone #: (circle Home or Cell)**		**Work #:**	
Email address (if available):				
Alternate Contact: Last	**First**	**MI**		**Relationship to Patient:**
Preferred Phone #: (circle Home or Cell)	**Secondary Phone #: (circle Home or Cell)**		**Work #:**	
Insurance Carrier:				
If BWC, please add claim # and MCO/contact (approved C-9 must be received before patient can be scheduled):				
Schedule Request (Please Check):				
☐ First Visit Consult **☐ Recheck of established patient in our clinic** **☐ ASAP (5-10 days)** **☐ Routine (2-4 weeks)**				
Physician Preference? ☐ Usman Khan, MD **☐ Jody Short, DO**				

Along with your request, please fax the following information:

- **Copy of the Insurance Card – front and back**
- **Medical records concerning the "reason for consult"**
- **Most current labs**
- **Medication list**
- **MRI/CT/Diagnostic Imaging reports of head or brain if done (patient to bring copies of imaging at time of appointment)**

Referring Physician:	
Address:	**Phone:**
	Fax:
Physician NPI #:	
Physician Signature:	
Name of individual submitting the form:	**Phone:**