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325 Briarwood Circle, Building 5
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810.227.2357, Fax: 810.227.0840
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734.844.5400, Fax: 734.844.7797
1051 North Canton Center Road
Canton, MI 48187

Livonia
734.432.7811, Fax: 734.432.7822
UM Center for Specialty Care
19900 Haggerty Road, Suite 111
Livonia, MI 48152

Milford
248.684.7337, Fax: 248.684.1286
320 West Commerce
Milford, MI 48381

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248.855.2071, Fax: 248.626.5028
5829 Maple Road, Suite 129
West Bloomfield, MI 48322

Ypsilanti — Clark Road
734.434.0404, Fax: 734.434.2735
4870 Clark Road, Suite 102
Ypsilanti, MI 48197

Ypsilanti — Reichert Building
734.434.2810, Fax: 734.434.7916
5333 McAuley Drive, Suite R6009
Ypsilanti, MI 48197

M-LINE 800.962.3555

More forms available at:
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COMPREHENSIVE OPHTHALMOLOGY

- **Ann Arbor** — 734.764.4190
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 - James G. Knaggs, M.D.
 - Donald G. Puro, M.D., Ph.D.
 - Michael W. Smith-Wheelock, M.D.
 - Joshua P. Vrabec, M.D.

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- **West Bloomfield**
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 - James L. Adams, M.D.
 - Harjeet Kaur, M.D., FRCS(I)

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- **Ann Arbor** — 734.764.5106
 - Sherry H. Day, O.D.
 - Helios T. Leung, Ph.D., O.D., FAAO
 - Karen Murphy, O.T.R.
 - Bradley W. Taylor, O.D., M.P.H.
 - Donna M. Wicker, O.D., FAAO

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 - Helios T. Leung, Ph.D., O.D., FAAO

- **Livonia and Milford**
 - Michael J. Lipson, O.D., FAAO

- **Ypsilanti — Clark Road**
 - Diane M. Jacobi, O.D.

CORNEA AND EXTERNAL DISEASE, CATARACT AND REFRACTIVE SURGERY

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 - Shahzad I. Mian, M.D.
 - Roni M. Shtein, M.D.
 - H. Kaz Soong, M.D.
 - Alan Sugar, M.D.

- **Brighton and Canton**
 - Shahzad I. Mian, M.D.

- **Milford**
 - Theresa M. Cooney, M.D.

EYE PLASTIC, ORBITAL AND FACIAL COSMETIC SURGERY

- **Ann Arbor** — 734.763.9142
 - Raymond S. Douglas, M.D., Ph.D.
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 - Bartley R. Frueh, M.D.
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 - Christine C. Nelson, M.D., FACS
 - Terry J. Smith, M.D.

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 - James L. Adams, M.D.

GLAUCOMA, CATARACT, AND ANTERIOR SEGMENT DISEASE

- **Ann Arbor** — 734.763.5874
 - Denise A. John, M.D.
 - Paul R. Lichter, M.D., FACS
 - Sayoko E. Moroi, M.D., Ph.D.
 - Joshua D. Stein, M.D., M.S.
 - Jennifer S. Weizer, M.D.

NEURO-OPHTHALMOLOGY

- **Ann Arbor** — 734.763.9142
 - Wayne T. Cornblath, M.D.
- **Ann Arbor, U-M Hospitals** — 734.763.5114
 - Jonathan D. Trobe, M.D.

PEDIATRIC OPHTHALMOLOGY AND ADULT STRABISMUS

- **Ann Arbor** — 734.764.7558
 - Steven M. Archer, M.D.
 - Monte A. Del Monte, M.D.
 - Carlton J. Foster, O.D.

- **Canton**
 - Steven M. Archer, M.D.

- **Ypsilanti — Reichert Building**
 - Gary S. Sandall, M.D., FACS

RETINA, UVEITIS, AND OCULAR ONCOLOGY

- **Ann Arbor** — 734.763.5906
 - Grant M. Comer, M.D.
 - Susan G. Elnier, M.D.
 - John R. Heckenlively, M.D.
 - Mark W. Johnson, M.D.
 - Stephen J. Saxe, M.D., FACS
 - David N. Zacks, M.D., Ph.D.

- **Brighton**
 - Grant M. Comer, M.D.



Outpatient Consult Request

Questions? Contact M-LINE at 800.962.3555
 Fax completed form directly to the clinic fax number provided or to M-LINE at 734.615.5886

To	Referred to: _____ (Specialty Clinic or Service) Physician Name / Location _____ (Optional)	
From	Referring Physician: _____ Office Name: _____ (Please Print) Office Contact: _____ Phone#: (____) _____ Fax#: (____) _____ E-Mail Address: _____	
PCP (If different from Referring)	Physician Name: _____ Office Name: _____ (Please Print) Office Contact: _____ Phone#: (____) _____ Fax#: (____) _____ E-Mail Address: _____	
Patient Information	Name: Last _____ First _____ (Please Print) (Please Print) UMHS Registration # (if available): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> 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: _____ <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Traditional <input type="checkbox"/> Medicare <input type="checkbox"/> None Medicaid: <input type="checkbox"/> HMO <input type="checkbox"/> Other Medicaid Insurance Plan: _____ Auto Accident? <input type="checkbox"/> Y <input type="checkbox"/> N Date of Injury _____ Work Comp? <input type="checkbox"/> Y <input type="checkbox"/> N Date of Injury _____	
Diagnosis and Reason for Consult or Therapy	UMHS Consult Request Guidelines www.med.umich.edu/umconsults	Appointment Requested: <input type="checkbox"/> Next Available <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 1 week <input type="checkbox"/> Other _____ Second Opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No
Requesting Physician	Physician Signature: (Required for PT and diagnostic tests only) _____ (Signature) (Date)	