



MICHIGAN HEAD•PAIN & NEUROLOGICAL INSTITUTE

3120 Professional Drive • Ann Arbor, Michigan 48104-5131
(734) 677-6000 (800) 518-3639 FAX: (734) 677-2422 www.MHNI.com



MHNI NEW PATIENT REFERRAL FORM

Fax this completed form to (734) 973-6982

You will receive a response within one business day and we will confirm the appointment with your patient.

CLINICAL DIVISIONS

HEAD PAIN
NEUROLOGY
GENERAL PAIN MANAGEMENT
SLEEP MEDICINE
BEHAVIORAL MEDICINE
PHYSICAL THERAPY
RESEARCH
NEURODIAGNOSTIC & LABORATORY
HOSPITAL TREATMENT UNIT

MEDICAL STAFF

Joel R. Saper, MD, FAAN
Founder and Director
Headache, Neurology & Pain Medicine
Certified, American Board of Psychiatry & Neurology (N)
American Board of Pain Medicine, Headache Medicine (UCNS)

Robert L. Hamel, PA-C, MM
Clinical Assistant to the Director

James R. Weintraub, DO
Headache, Neurology & Sleep Medicine
Certified, American Osteopathic Board of Psychiatry
& Neurology (N), American Board of Sleep Medicine
Headache Medicine (UCNS)

Alicia R. Prestegaard, MD
Headache, Neurology & Pain Medicine
Certified, American Board of Psychiatry & Neurology (N)
American Board of Pain Medicine, Headache Medicine (UCNS)

Shamas Moheyuddin, MD
Pain Anesthesiology
Certified, American Board of Anesthesiology

Nauman Tariq, MD
Headache & Neurology
Certified, American Board of Psychiatry and Neurology (N)

Gayle A. Antonelli, PA-C
Certified Physician Assistant

BEHAVIORAL MEDICINE

Alvin E. Lake III, PhD, FAHS
Division Director
Clinical Psychologist (Licensed)

Jeffrey D. Pingel, PhD
Clinical Psychologist (Licensed)

Lisa B. Ensfield, PhD
Clinical Psychologist (Licensed)

PHYSICAL THERAPY

Andrea K. Sherman, PT, DPT, CFC
Physical Therapy Coordinator

NURSING

Mary E. Brunett, RN, BSN
Head Nurse

Mary M. Kroll, RN, BSN
Clinical Coordinator

RESEARCH

Shawn M. Szalay, RN, BSN
Director, Clinical Trials

Marjorie E. Winters, RN, BSN
Contracts Management, Clinical Trials

ADMINISTRATION

Scott F. Madden, FACHE
Vice President & Administrator

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: () _____ Work: () _____

Cell: () _____ Gender: M F

Date of Birth: ____ / ____ / ____ SSN: ____ - ____ - ____

Primary Insurance: _____

Group #: _____ Contract #: _____

Secondary Insurance: _____

Group #: _____ Contract #: _____

Referring Physician: _____

Referring Practice Name: _____

Phone: () _____ Fax: () _____

Reason for Referral: _____

If possible, please fax any pertinent office notes and diagnostic/radiologic reports along with this form to: (734) 973-6982, attn: New Patient Representative

THANK YOU FOR YOUR REFERRAL!

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A National Referral Center
MHNI is the Nation's First Comprehensive Head•Pain Treatment Center