REALWAVE
NEUROPATHY TREATMENT CENTERS

# Referral Form

**Please attach the patient's demographic and insurance information, as well as notes from a recent office visit or physical.**

Patient's Name: _____ DOB: _____

Insurance Plan:_____ Insurance ID#:_____

Insurance Plan Provider Phone #:_____

Insurance Plan 2:_____ Insurance ID#:_____

Insurance Plan 2 Provider Phone #:_____

Patient Phone: _____ Patient E-mail:_____

- ☐ Diabetic Peripheral Neuropathy
- ☐ Idiopathic Neuropathy
- ☐ Other (Explain)
- ☐ Evaluate and Treat

Provider's Name:_____

Provider's Signature:_____

Notes:

_____

_____

## Please check the appropriate center:

| | |
|---|---|
| ☐ **Dearborn** 2142 Monroe Street | 313-293-8869 Phone |
| ☐ **Livonia** 14600 Farmington Road, Suite 105 | 734-821-8707 Phone |
| ☐ **Rochester** 1000 West University Drive, Suite 314 | 947-282-7730 Phone |
| ☐ **Southfield** 29877 Telegraph Road, Suite LL-12 | 248-213-6222 Phone |
| ☐ **Warren** 11270 East 13 Mile Road Suite 3 | 947-282-6260 Phone |

**Fax referral forms to 313-329-2646**

**For new patient appointments, please have patients call 1-877-301-3441 or visit www.realwavecenters.com/appointment**