



Outpatient Consult Request

Questions? Contact M-LINE at 800-962-3555

Fax completed form directly to the clinic fax

<p>To</p>	<p>Referred to (Specialty Clinic or Service): _____ (Please Print)</p> <p>Physician Name / Location _____ (Optional)</p>		
<p>From</p>	<p>Referring Physician: _____ Office Name: _____ (Please Print)</p> <p>Office Contact: _____ Phone#: (____) _____</p> <p>Fax#: (____) _____ E-Mail Address: _____</p>		
<p>PCP (If different from Referring)</p>	<p>Physician Name: _____ Office Name: _____ (Please Print)</p> <p>Office Contact: _____ Phone#: (____) _____</p> <p>Fax#: (____) _____ E-Mail Address: _____</p>		
<p>Patient Information</p>	<p>Name: Last _____ First _____</p> <p>UMHS Registration # (if available): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F DOB: _____</p> <p>Telephone: Home (____) _____ Work: (____) _____ Other: (____) _____</p> <p>Address: _____ City: _____ State: _____ Zip: _____</p>		
<p>Other Contact Information (if applicable)</p>	<p>Mother's Name: _____ Father's Name: _____</p> <p>Other (please explain): _____</p> <p>Telephone: Home(____) _____ Work: (____) _____ Other: (____) _____</p>		
<p>Insurance Information</p>	<p>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</p> <p>Medicaid: <input type="checkbox"/> HMO <input type="checkbox"/> Other Medicaid Insurance Plan: _____</p> <p>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 _____</p>		
<p>Diagnosis and Reason for Consult or Therapy</p>	<table border="1"> <tr> <td data-bbox="297 1444 1125 1701"> <p><u>Reason For Consult Request</u></p> <p><input type="checkbox"/> Consult only <input type="checkbox"/> Consult and Treatment</p> <p>For the following (signs/symptoms): _____</p> <p>_____</p> <p>_____</p> </td> <td data-bbox="1141 1444 1528 1686"> <p>Appointment Requested:</p> <p><input type="checkbox"/> Next Available</p> <p><input type="checkbox"/> Within 2 weeks</p> <p><input type="checkbox"/> Within 1 week</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p>Second Opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> </tr> </table> <p><u>Care Management:</u> UMHS Consult Request Guidelines web site: www.med.umich.edu/umconsults</p>	<p><u>Reason For Consult Request</u></p> <p><input type="checkbox"/> Consult only <input type="checkbox"/> Consult and Treatment</p> <p>For the following (signs/symptoms): _____</p> <p>_____</p> <p>_____</p>	<p>Appointment Requested:</p> <p><input type="checkbox"/> Next Available</p> <p><input type="checkbox"/> Within 2 weeks</p> <p><input type="checkbox"/> Within 1 week</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p>Second Opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Requesting Physician</p>	<p>Physician Signature: (Required for PT and diagnostic test only)</p> <p>_____</p> <p>(Signature) (Date)</p>		