UW Health

REQUEST FOR CLINIC APPOINTMENT

For urgent appointment requests, please call the clinic directly.

Index to Consult/Referral/Transfer

Date: _____

EPIC/UWHC#: _____

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

This form may be used to request an appointment in any UW Health adult or pediatric specialty clinic.

Please provide all required (*) information. Missing information may result in delayed processing of this request.

Patient Information

Patient Name*: _____ Date of birth*: ___/____/____
Patient Address*: _____ Gender*: ☐ Male ☐ Female
Primary Care Provider:_____ City*: _____ State*: _____ Zip*: _____

Best phone number to contact patient or representative (parent, guardian or Healthcare POA) check the box below:

☐ Home #: _____ ☐ Work #: _____ ☐ Cell #: _____

Interpreter needed? ☐ Yes ☐ No Language: _____

INSURANCE INFORMATION:

Name of insurance*: _____ Subscriber name*: _____
Subscriber/Member/Employee ID #*: _____ Effective from date*: ____/____/____
Group number: _____

***Please fax a copy of the insurance card with the request form if possible.**

We may contact the patient directly for additional information, please notify the patient of this appointment request.

Referring Provider

Clinic Name*: _____
Name*: _____
City: _____

Contact Person Within Your Clinic

Name*: _____
Phone #*: _____
Fax #*: _____

Medical Records Dept. Fax #: _____ (Complete if this is preferred location to send request for additional information)

INFORMATION APPEARING BELOW SHOULD BE VIEWED ONLY AS NEEDED TO ARRANGE FOR OR PROVIDE CARE

Specialty or Specialty Clinic(s) requested*: _____
Reason for requested appointment*: _____
_____
Test/Procedure Request: _____

What question regarding this patient's medical care would you like the specialist to answer (reason for referral): _____
_____
_____

Specific Physician/NP/PA requested:_____
Tentative diagnosis: _____
Has the patient previously been seen by a specialist for this problem? ☐ Yes ☐ No
If yes, who did he/she see and date of last visit? _____

Related testing that has been done regarding the above diagnosis: _____
_____

☐ Schedule in first available appointment
☐ Appointment for consult (opinion/advice)
☐ Transfer all care for above diagnosis (patient will be transferred back when deemed appropriate)

Please fax any records, reports, or test results which are pertinent to this referral

PLEASE FAX FORM TO: (608) 203-2661 **TOLL FREE FAX #: (888) 875-8490**

For additional copies of this form go to uwhealth.org/referral

Referring Provider Signature: _____ Date: _____ Time: _____ Pager#: _____

This form is for use by non-UW Health providers