Outpatient Consult Request

Questions? Contact M-LINE at 800-962-3555
Fax completed form directly to the clinic fax number

To	Referred to:______________________________ (Specialty Clinic or Service) Physician Name / Location ______________________________ (Optional)
From	Referring Physician: ____________________ (Please Print) Office Name:__________________ Office Contact: ______________________ Phone#: (____)____________________ Fax#: (______)______________________ E-Mail Address: ____________________ ☐ **Please Contact Our Office With Clinic Appointment Date/Time**
PCP (If different from Referring)	Physician Name:____________________ (Please Print) Office Name:_________________ Office Contact: ______________________ Phone#: (____)____________________ Fax#: (______)______________________ E-Mail Address: ____________________ ☐ **Please Contact Our Office With Clinic Appointment Date/Time**
Patient Information	Name: Last____________________ First____________________ UMHS Medical Record # (if available): ____________ Gender: ☐M ☐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: ______________ ☐HMO ☐PPO ☐POS ☐Traditional ☐Medicare ☐None Medicaid: ☐HMO ☐Other Medicaid Insurance Plan: ____________________ Auto Accident? ☐Y ☐N Date of Injury _________ Work Comp? ☐Y ☐N Date of Injury ______
Diagnosis and Reason for Consult or Therapy	**UMHS Consult Request Guidelines** www.med.umich.edu/umconsults **Appointment Requested:** ☐ Next Available ☐ Within 2 weeks ☐ Within 1 week ☐ Other ____________________ Second Opinion? ☐Yes ☐No
Requesting Physician	**Physician Signature:** (Required for PT and diagnostic test only) ____ (Signature) (Date)