

**UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS**

**Outpatient Consult Request**

BIRTHDATE

NAME

Reg. No.

Referred to: \_\_\_\_\_

(Specialty / Clinic)

\_\_\_\_\_  
(Physician)

\_\_\_\_\_  
(Location)

<b>Referral Source</b>	Referring Physician Name _____ Phys.# _____
	Clinic Name _____ Phone# ( ) _____
	Contact: _____ Fax# ( ) _____
<b>Clinical Information</b>	<b>Patient Demographics:</b> <input type="checkbox"/> Attached (Careweb or PM)
	<b>Documents:</b> <input type="checkbox"/> See Careweb / Dictation Date(s) _____
	<b>Path:</b> <input type="checkbox"/> See Careweb / Date(s) _____
	<b>Rad:</b> <input type="checkbox"/> See Careweb / Date(s) _____
	<b>Other:</b> _____ <input type="checkbox"/> Attached <input type="checkbox"/> See Careweb / Date(s) _____
<b>Insurance Referral / Authorization:</b> <input type="checkbox"/> Attached <input type="checkbox"/> Refer to IDX / OutReach Referral# _____	
<b>Reason for Consult</b>	<input type="checkbox"/> <b>Urgent</b>
	<input type="checkbox"/> 2 wks <input type="checkbox"/> Next Available
<b>PT, OT Speech</b>	<b>Ordering Physician Signature:</b> _____ Ordering Physician's Signature Date
<b>Patient Scheduling Information</b>	<b>To schedule an appointment:</b> Please call the _____ clinic at (_____) _____
	Contact Person: (if applicable) _____

2202134



Rev. 8/04

MEDICAL RECORD



University of Michigan Health System

**OUTPATIENT CONSULT REQUEST**

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