

**UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS**

**Outpatient Consult Request**

Birth date: \_\_\_\_\_

Name: \_\_\_\_\_

Reg. No.: \_\_\_\_\_

From	
To	Specialty Service: <u>Physical Therapy</u> Therapist: _____ Address: _____ _____ Phone #: _____ _____ Fax #: _____ _____
Diagnosis (Please check all that apply)	<input type="checkbox"/> Pelvic muscle weakness <input type="checkbox"/> Pelvic muscle Spasm <input type="checkbox"/> Interstitial Cystitis <input type="checkbox"/> Endometriosis <input type="checkbox"/> Constipation / defecation disorder <input type="checkbox"/> Lower back / sacral pain <input type="checkbox"/> Urinary / Fecal Incontinence <input type="checkbox"/> Myofascial / abdominal / scar restrictions <input type="checkbox"/> Vulvodynia / vestibulitis <input type="checkbox"/> Anorectal pain syndrome <input type="checkbox"/> Other: _____
Consultant's Statement	<input type="checkbox"/> Evaluate and treat x 3 months <input type="checkbox"/> Electrical stimulation unit / surface EMG for home use <input type="checkbox"/> TENS / IFC <input type="checkbox"/> Other: _____
Requesting or Ordering Physician's Signature	_____ Physicians Signature Date _____ Physician Name Dr. #
Patient and Insurance Information	Patient's Daytime Phone # ( ) _____ Primary Insurance Type: _____ IDX / OutReach Referral # or Auth #: _____ ICD9# _____
Patient Appointment Information	Your physician has recommended you be seen by: _____ Specialty Clinic / Physician Specialty Clinic Phone # ( ) _____ Fax Sent: _____ Date <input type="checkbox"/> Your appointment has been scheduled (Itinerary attached) <input type="checkbox"/> You will be contacted by the Specialty Clinic to schedule your appointment <input type="checkbox"/> Please call the Specialty Clinic to schedule your appointment