



Outpatient Consult Request

Questions? Contact M-LINE at 800-962-3555
 Fax completed form directly to the clinic fax number provided or to M-LINE at 734-615-5886

To	Referred to: _____ <small>(Specialty Clinic or Service)</small> Physician Name / Location _____ <small>(Optional)</small>	
From	Referring Physician: _____ Office Name: _____ <small>(Please Print)</small> Office Contact: _____ Phone#: (____) _____ Fax#: (____) _____ E-Mail Address: _____	
PCP <small>(If different from Referring)</small>	Physician Name: _____ Office Name: _____ <small>(Please Print)</small> Office Contact: _____ Phone#: (____) _____ Fax#: (____) _____ E-Mail Address: _____	
Patient Information	Name: Last _____ First _____ <small>(Please Print) (Please Print)</small> UMHS Registration # (if available): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F DOB: _____ Telephone: Home (____) _____ Work: (____) _____ Other: (____) _____ Address: _____ City: _____ State: _____ Zip: _____	
Other Contact Information <small>(if applicable)</small>	Mother's Name: _____ Father's Name: _____ Other (please explain): _____ Telephone: Home(____) _____ Work: (____) _____ Other: (____) _____	
Insurance Information	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 Medicaid: <input type="checkbox"/> HMO <input type="checkbox"/> Other Medicaid Insurance Plan: _____ 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 _____	
Diagnosis and Reason for Consult or Therapy	<u>UMHS Consult Request Guidelines</u> www.med.umich.edu/umconsults	Appointment Requested: <input type="checkbox"/> Next Available <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 1 week <input type="checkbox"/> Other _____ Second Opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No
Requesting Physician	Physician Signature: (Required for PT and diagnostic tests only) _____ <small>(Signature) (Date)</small>	