Outpatient Consult Request

Questions? Contact M-LINE at 800-962-3555

Fax completed form directly to the clinic fax number provided

Refer Patient To	UM Clinic Referred to: ________________ UM Provider: ________________ UM Clinic Location: ________________
Referred From	Referring Physician: ________________ (Please Print) Office Name: ________________ Office Contact: ________________ Phone#: (____)________________ Fax#: (______)________________ E-Mail Address: ________________
PCP (If different from Referring)	Physician Name: ________________ (Please Print) Office Name: ________________ Office Contact: ________________ Phone#: (____)________________ Fax#: (______)________________ E-Mail Address: ________________
Patient Information	Name: Last________________ (Please Print) First________________ (Please Print) UMHS Registration # (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	Patient Diagnosis: ________________ Reason for Consult: ________________ Appointment Requested: ❑ Next Available ❑ Within 2 weeks other Second Opinion? ❑Yes ❑No
Instructions for Uploading Images Online	Visit **uofmhealth.org/uploadimages** for additional information on how to send your patient images electronically to University of Michigan Health. List Radiology Test: Date: Test Location: List Radiology Test: Date: Test Location: List Radiology Test: Date: Test Location:
Requesting Physician	**Physician Signature:** (Required for PT and diagnostic tests only) ________________________________ (Signature) (Date)