



Department of Internal Medicine
Scleroderma Program
 Division of Rheumatology
 1500 East Medical Center Drive
 Ann Arbor, MI 48109-5358
 M-LINE: 1-800-962-3555
 Clinic: 734-647-5900 Fax: 734-936-8067

REQUEST FOR CONSULTATION

PLEASE COMPLETE FORM AND FAX TO 734-936-8067. Missing information may delay the referral process.

Today's Date: _____ Contact Name & Number: _____

Section 1: Patient Information UM Registration #: (Internal use only) _____

Patient Name: (PLEASE PRINT) _____

Address: _____ City/State/Zip: _____

Date of Birth: ___/___/___ Sex: F M Social Security #: _____

Telephone #s: (home): (_____) _____ (work): (_____) _____

Patient's Insurance (REQUIRED): If referral authorization is required, please fax to 734-936-8067

M-CARE BCN BCBS Medicaid Other _____ HMO POS PPO

Section 2: Physician Information (REQUIRED)

Referring Physician's Name: _____ UPIN # _____

Address: _____ City/State/Zip: _____

Telephone #: (_____) _____ Fax Number: (_____) _____

Primary Care Physician's Name: _____ UPIN # _____

Address: _____ City/State/Zip: _____

Telephone #: (_____) _____ Fax Number: (_____) _____

Section 3: Patient History Information (REQUIRED)

Diagnosis: _____

Rule Out: _____

To avoid duplication of tests, please list relevant studies and date completed: Fax reports if not performed at U of M

X-Ray (list type) _____ date: ___/___/___ Location: _____

MRI (list type) _____ date: ___/___/___ Location: _____

Other (List) _____ date: ___/___/___ Location: _____

Please give a brief history of patient's medical history:

For UMHS Use Only: UMHS Rheumatology Physician Recommendation

- Emergent – Refer to consult team
- Urgent – Schedule within _____ Weeks
- Non-urgent – Schedule within _____ Months
- Schedule with Dr. _____
- Schedule In _____ Clinic

Comments:

Please fax consultation request form and medical documentation to (734) 936-8067

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