University of Michigan Health System

Outpatient Consult Request

FAX: (734) 615-1532

Questions? Contact the Speech-Language Pathology Clinic directly at (734) 763-4003

◄ Fax completed form directly to our clinic

TO	SERVICE: **SPEECH–LANGUAGE PATHOLOGY** CLINICIAN NAME: _____ (OPTIONAL)	**PATIENT INFORMATION** **NAME:** _____ **BIRTHDATE:** _____ **UM REG #** (if available)**:** _____
FROM	REFERRING PHYSICIAN: _____ (PLEASE PRINT) NPI #: _____ ⊗ _____ (PHYSICIAN SIGNATURE REQUIRED) _____ **(DATE)** OFFICE CONTACT: _____ ***** REQUIRED ***** FAX#: (_____)_____	**PATIENT'S** **HOME PHONE:** _____ **WORK PHONE:** _____ PHONE#: _____ E-MAIL ADDRESS: _____
PCP (IF DIFFERENT FROM REFERRING) (REQUIRED FOR HMOS)	PHYSICIAN NAME:_____ (PLEASE PRINT) OFFICE CONTACT: _____ FAX#: (_____)_____	OFFICE NAME: _____ PHONE#: _____ E-MAIL ADDRESS: _____
DIAGNOSIS & REASON FOR CONSULT	**MEDICAL DX:** _____ **PLEASE CHECK ALL THAT APPLY:** ☐ SPEECH, LANGUAGE EVALUATION ☐ TRACH EVALUATION ☐ SPEAKING VALVE EVAL/PLACEMENT ☐ VOICE EVALUATION ☐ SCOPE WITH MD IN CLINIC. ☐ CLINICAL SWALLOWING EVALUATION ☐ VIDEOFLUOROSCOPIC SWALLOW STUDY - VFSS ☐ NASOMETRY ☐ AUGMENTATIVE COMMUNICATION EVALUATION ☐ OTHER: (PLEASE IDENTIFY) _____	**APPOINTMENT REQUESTED:** ☐ NEXT AVAILABLE ☐ SURGERY PENDING DATE_____ ☐ OTHER _____
OTHER **CONTACT INFORMATION** (IF APPLICABLE)	NAME:_____ RELATIONSHIP: _____ OTHER (PLEASE EXPLAIN):_____ TELEPHONE: HOME_____ WORK: _____ OTHER: _____	
INSURANCE INFORMATION	INSURANCE INFO: _____ ☐HMO ☐PPO ☐POS ☐TRADITIONAL ☐MEDICARE ☐NONE MEDICAID: ☐ FULL ☐HMO ☐OTHER MEDICAID INSURANCE PLAN: _____ AUTO ACCIDENT? ☐Y ☐N DATE OF INJURY _____ WORK COMP? ☐Y ☐N DATE OF INJURY _____	