

Outpatient Consult Request

BIRTHDATE

NAME

REG NO

From	Clinic Name: _____
	Clinic Phone #: _____ Clinic Fax #: _____

To	Specialty Clinic or Service: _____
	Physician: _____ Location: _____

Clinical Information	Careweb Documents
	Dictated Notes: Date(s) of Service: _____
	Path: Date(s) _____
	Rad: Date(s) _____
	Non-Careweb Documents Attached: _____ (Please list)

Diagnosis & Reason for Consult or Therapy	<input type="checkbox"/> Within 1 week <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Next available <input type="checkbox"/> Other: _____

Requesting or Ordering Physician's Signature	_____	_____
	Physician Signature	Date
	_____	_____
	Physician Name – PLEASE PRINT	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 # (____) _____	
	<table border="1"> <tr> <td>Fax Sent: _____</td> </tr> <tr> <td>Date _____</td> </tr> </table>	Fax Sent: _____
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	