MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Outpatient Consult Request

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

Fax completed form directly to the clinic fax

To	**Referred to** (Specialty Clinic or Service):_____ (Please Print) Physician Name / Location _____ (Optional)
From	Referring Physician: _____ Office Name:_____ (Please Print) Office Contact: _____ Phone#: (____)_____ Fax#: (_____)_____ E-Mail Address: _____
PCP (If different from Referring)	Physician Name:_____ Office Name:_____ (Please Print) Office Contact: _____ Phone#: (____)_____ Fax#: (_____)_____ E-Mail Address: _____
Patient Information	Name: Last_____ First_____ 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	**Reason For Consult Request** ☐ Consult only ☐ Consult and Treatment For the following (signs/symptoms):_____ _____ _____ **Appointment Requested:** ☐ Next Available ☐ Within 2 weeks ☐ Within 1 week ☐ Other _____ Second Opinion? ☐Yes ☐No **Care Management:** UMHS Consult Request Guidelines web site: www.med.umich.edu/umconsults
Requesting Physician	**Physician Signature:** (Required for PT and diagnostic test only) _____ (Signature) (Date)