

# THE UNIVERSITY OF KANSAS HOSPITAL

## PATIENT APPOINTMENT/CONSULTATION REQUEST FORM

Fax completed form to the **Consultation and Referral Services Center at 913-588-5785.**  
For questions call 913-588-5862 or 877-588-5862.

### **PART I - REFERRING PHYSICIAN INFORMATION**

Today's date: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Practice name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### **PART II – PATIENT INFORMATION**

Patient name: \_\_\_\_\_ Gender: M F

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Guardian name: (Authorized person) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Day phone: \_\_\_\_\_ Interpreter needed? Y N \_\_\_\_\_  
Specify language

Insurance: \_\_\_\_\_ Guarantor: \_\_\_\_\_

### **PART III – APPOINTMENT INFORMATION**

Presenting diagnosis/problem: \_\_\_\_\_

\_\_\_\_\_ ROUTINE (Next available appointment) YES NO

\_\_\_\_\_ IMMEDIATE/URGENT YES NO

*(For Immediate/urgent requests, please specify reason below. Medical records must be faxed for these requests).*

\_\_\_\_\_

Consulting physician (if known): \_\_\_\_\_

Department/Specialty: \_\_\_\_\_

- YES NO Requesting advice/opinion with treatment and continued co-management.
- YES NO Requesting advice/opinion.
- YES NO Requesting transfer of care for this problem.

**A copy of this consultation request should be filed in the medical record of both the originating physician and the consulting physician. If this is a verbal request, a copy of this form should be faxed to the originating physician.**

### **FOR CALL CENTER USE ONLY—DO NOT WRITE BELOW THIS SECTION**

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Location: \_\_\_\_\_

**Insurance referral must be faxed to 913-588-5785 before the appointment can be confirmed.**