University of Michigan Health System

Department of Internal Medicine
Division of Gastroenterology
1500 East Medical Center Drive
Ann Arbor, MI 48109-5358
M-LINE: 1-800-962-3555
GI Clinic: 734-647-5944 GI Fax: 734-936-5458
Liver Clinic: 734-936-0499 Liver Fax: 734-764-9435

REQUEST FOR CONSULTATION

PLEASE COMPLETE FORM AND FAX TO 734-936-5458. Missing information WILL delay the scheduling of your patient.

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

Section 1: Patient Information (REQUIRED)

Patient Name: **(PLEASE PRINT)** _____

Address: _____ City/State/Zip: _____

Date of Birth: ____/____/____ Sex: F ☐ M ☐

Telephone #s: _____ Other day time contact #: (_____)_____

Patient's Insurance (REQUIRED): **If referral authorization is required, please fax to 734-936-5458**

☐ Medicare ☐ BCN ☐ BCBS ☐ Medicaid ☐ Other _____ ☐ **HMO** ☐ **POS** ☐ **PPO**

Section 2: Physician Information (REQUIRED) If referring physician is not Primary Care Physician, provide PCP info

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: _____

_____

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

☐ Procedures (list type)_____ date: ___/___/___ Location: _____

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

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

Appointment Requested:

☐ Urgent = Within 2 Weeks ☐ Within 3-6 Weeks

☐ Routine = Next Available

Schedule with Dr. _____

Comments:

Please fax consultation request form, medical documentation, and managed care referral to (734) 936-5458