University of Michigan Health System

DIVISION OF HEPATOLOGY
Room 5E14
300 N. Ingalls Street, SPC 5410
Ann Arbor, MI 48109-5410
844-233-0433/734-998-1453 (fax)

REQUEST FOR CONSULTATION

PLEASE COMPLETE FORM AND FAX TO 734-998-1453. 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: (home**)**: (_____)_____ Other day time contact #: (_____)_____

Patient's Insurance (REQUIRED): **If referral authorization is required, please fax to 734-998-2647**

☐ 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: _____ NPI # _____

Address: _____ City/State/Zip: _____

Telephone #:(_____)_____ Fax Number:(_____)_____

Primary Care Physician's Name: _____ NPI # _____

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, insurance referral and authorization to (734) 764-9435