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. Or visit kumed.com/consult.

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).*

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Consulting physician (if known):____________________ **OR** First available: YES ☐ NO ☐

Department/Specialty: Rehabilitation Medicine - Spine and Pain Program

☐ 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.

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