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).*

_____

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

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.