

UCSF Medical Center

Ambulatory Services

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION

DATE

REQUEST FOR CONSULTATION

Requesting provider office: To facilitate this request, please complete all of the items listed below

Request from: _____ MD/NP Date: ___ / ___ / ___

TO: Consultant/Clinic/Practice: _____ Specialty: _____

For consultant:

Please provide an opinion and consult for the above named patient. This patient is being sent to you for the following reasons: _____

We are including the following finding/test result that lead to this consult: _____

The best way to contact the patient Monday – Friday, between 8 a.m. and 5 p.m. is by:

Letter FAX Telephone

The **patient's** contact information is :

Address: _____

Telephone: Home _____ Work/Cell _____ FAX _____

The patient's insurance is: _____

We understand that you may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation, in support of the consultation process. We look forward to your opinion and plan of care. Please contact our office in the following way:

Letter FAX Telephone

Requesting practice/ contact information here:

Address: _____

Telephone: _____ FAX # _____

Physician Cell# _____ Pager# _____ On pagerbox

UCSF Practices: attending/NP signature and provider number required:

Requesting Provider: _____ Provider's I.D.#: _____

Attending MD/NP signature: _____ ID# _____ Date ___ / ___ / ___

For internal use only:

Date Received: ___ / ___ / ___ Appointment Scheduled: ___ / ___ / ___

Provider: _____ Patient/office notified: ___ / ___ / ___

Authorization status:

Treatment Authorization Request (TAR) required pending completed ___ / ___ / ___ date

Brown and Toland Medical Group referral required pending completed ___ / ___ / ___ date

Consultant Brief Note (optional): _____

Physician signature: _____ ID# _____ Date: ___ / ___ / ___

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