UW Health

REQUEST FOR CLINIC APPOINTMENT

For urgent appointment requests, please call the clinic directly

Date: _____
Index to Consult/Referral/Transfer

EPIC/UWHC# _____

UW Health **www.uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)

This form may be used to request an appointment in any UW Health adult or pediatric specialty clinic

Patient Information Date of Birth: _____
Patient Name: _____ Gender: Male / Female (circle one)
Patient Address: _____ City: _____ State: ____ Zip Code: _____
Primary Care Provider: _____
Name of Insurance: _____ Subscriber Name: _____
Subscriber/Member/Employee ID # _____ Effective from Date: _____ Group Number _____
Interpreter Needed? Yes / No (circle one) Language: _____
If patient is under the age of 18 or if other than patient is arranging appointment, contact name: _____
_____ (parent, representative or guardian)
Best phone # to contact patient or representative:

☐ Home #: _____ ☐ Work #: _____ ☐ Cell #: _____

We may contact the patient directly for additional information, please notify the patient of this appointment request.

Please fax copy of the insurance card with the request form if possible.

Referring Provider:
Clinic Name: _____
Name: _____
City: _____

Contact Person Within Your Clinic:
Name: _____
Phone #: _____
Fax #: _____

Medical Records Dept. Fax #: _____ (Complete if this is preferred location to send request for additional information)

INFORMATION APPEARING BELOW SHOULD BE VIEWED ONLY AS NEEDED TO ARRANGE FOR OR PROVIDE CARE

Appointment/Test/Procedure Requested at: _____

_____

_____ **Specialty Clinic(s)**

☐ **Schedule in first available appointment** ☐ **Schedule with** _____ **MD/NP/PA**
Tentative Diagnosis: _____

What question regarding this patient's medical care would you like the specialist to answer (Reason for Referral):

_____

_____

Has the patient previously been seen by a specialist for this problem? Yes / No (circle one)
If yes, who did he/she see and date of last visit? _____
Related testing that has been done regarding the above diagnosis (Please fax copies of reports with this request):

_____

☐ Appointment for consult (opinion / advice)

☐ Transfer all care for above diagnosis (Patient will be transferred back when deemed appropriate)

Referring Provider Signature _____ Date _____ Time _____

PLEASE FAX FORM TO: 608-203-2661 TOLL FREE FAX # 888-875-8490

For additional copies of this form go to uwhealth.org/referral