



REQUEST FOR CLINIC APPOINTMENT

For urgent appointment requests,
please call the clinic directly.

University of Wisconsin Physicians*
American Family Children's Hospital
University of Wisconsin Hospital & Clinics

Date: _____

EPIC/UWHC# _____

Patient Information

Date of Birth: _____

Patient Name: _____ Gender: Male / Female (circle one)

Patient Address: _____ City: _____ State: _____ Zip Code: _____

Primary Care Provider: _____

Name of Insurance: _____

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:

Contact Person Within Your Clinic:

Clinic Name: _____

Name: _____

Name: _____

Phone #: _____

City: _____

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 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: _____

*University of Wisconsin Physicians practice at UW Hospital & Clinics and Meriter Hospital. The choice of physicians may determine future location of inpatient admission or surgery. If there is a preference for a hospital service provider, please indicate so here:

Please complete all areas on form. Incomplete information may delay scheduling of patient appointment.

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

For additional copies of this form go to <http://www.uwhealth.org/referral>

• This form is for use by non-UW Health providers •