

REQUEST FOR CONSULTATION

PHYSICIAN REFERRAL SERVICE

Adults: 612-672-7000 Children: 888-KIDS-UMN
Toll free 888-318-DOCS (3627) (888-543-7866)
Fax 612-884-0659
University of Minnesota Medical Center, Fairview
University of Minnesota Children's Hospital, Fairview
www.umphysicians.umn.edu

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name: Date:
Clinic Name: UPIN/NPI:
Clinic Address:
City: State: Zip Code:
Telephone Number: Fax Number:
Contact Name: Contact's Direct #:

PATIENT INFORMATION

Gender: Male Female
Name: First Middle Last
Address:
City: State: Zip Code:
County: Date of Birth:
Parent's Name (if minor): Spouse's First Name (if any):
Previous Name (if any): Home Telephone Number:
Work Telephone Number: Mobile Telephone Number:
Contact Instructions: (preferred number/best time to reach/OK to leave message)

REQUESTED APPOINTMENT

Reason for Referral, Symptoms and Diagnosis: (please be specific and state area of involvement)

Onset/Duration: Pertinent prior surgery or testing (specify dates):

Specialty requested: Physician requested (if any):

Thank you for allowing us to participate in caring for your patient. We will contact you regarding this referral within 24 hours (or the next business day).