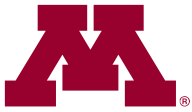

HEALTH[SM]
UNIVERSITY OF MINNESOTA

PHYSICIAN REFERRAL SERVICE
Adults: 612-672-7000
Toll free 888-318-3627
Fax 612-884-0659
Children: 888-KIDS-UMN
(888-543-7866)

mhealth.org/refer

REQUEST FOR CONSULTATION

☐ Consultation ☐ Referral

REFERRING PHYSICIAN INFORMATION

Date: ______________________

Referring Physician's Name: ______________________ **UPIN/NPI:** ______________________

Clinic Name: ______________________

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:** ______________________

Mobile Telephone Number: ______________________ **Work 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).