



THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

OUTPATIENT CONSULT REQUEST FORM

Patient Label Here
For UTMC Use Only

Please type or print/write legibly

Please fax this along with insurance information to the clinical area you are referring your patient. For questions about this form, call Physician Referral and Resources at 800-556-5444 or 419-383-4444.

To access this form online go to: utmc.utoledo.edu/patientguests/justforphysicians

To	Date _____	
	Referred to: _____ <i>(Specialty Clinic or Service)</i>	_____ <i>(Physician Name)</i>
From	Referring Physician: _____ Office Name: _____ <i>(Please Print)</i>	
	Office Contact: _____	Phone #: _____ Fax # _____
PCP <i>(If different from Referring Physician)</i>	Physician Name: _____ Office Name: _____ <i>(Please Print)</i>	
	Office Contact: _____	Phone #: _____ Fax # _____
Diagnosis and Reason for Consult or Therapy	** Please fax the last office visit notes and any test results with this form.	
	Appointment Requested: <input type="checkbox"/> Next available <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 1 week <input type="checkbox"/> Within 24 hours Other: _____	
Patient Information	Second Opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Name: Last _____ First _____ UTMC Registration # <i>(if available)</i> : _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F D.O.B.: _____ Phone: Home () _____ Work () _____ Other () _____ Address: _____ City: _____ State: _____	
Insurance Information	Insurance: _____ <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Traditional <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> None Name of insurance plan, i.e., Medical Mutual, Medicare Advantage, etc. _____ Auto Accident? <input type="checkbox"/> Y <input type="checkbox"/> N Date of Injury: _____ Workers Comp? <input type="checkbox"/> Y <input type="checkbox"/> N Date of Injury: _____	
	SELF PAY ** Self pay patients are required to contact Patient Financial Services @ 419.383.4044 at the time an appointment is scheduled to arrange a payment plan.	

APPOINTMENT SCHEDULED:

Dr. _____ Date of Appointment _____ Time _____

**** Patients will be contacted with the date of their appointment unless otherwise specified by the referring physician.**

