UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

Outpatient Consult Request

Questions? Contact M-LINE at 800-962-3555

Fax completed form directly to the clinic fax number provided

Refer Patient To	UM Specialty:
Referral From	Referring Physician: _____ Office Contact: _____ Phone #: _____ Fax #: _____
Patient Information	Name: _____ (Last) _____ (First) UMHS Registration #: _____ (if available) Gender: ❑ M ❑ F DOB: _____ Telephone: _____ (Home) _____ (Work) _____ (Cell) _____ (Address) _____ (City) _____ (State) _____ (Zip Code)
Other Contact Information	Mother's Name: _____ Father's Name: _____ Other (please explain): _____ Telephone: _____ (Home) _____ (Work) _____ (Cell)
Diagnosis and Reason for Consult or Therapy	Patient Diagnosis: _____ Reason for Consult: _____ Second Opinion? ❑ Yes ❑ No Priority: ❑ Urgent ❑ Routine
Instructions for Uploading Images Online	Visit **michmed.org/uploadimages** for additional information on how to send your patient images electronically to University of Michigan Health. List Radiology Test: _____ Date: _____ Test Location: _____ List Radiology Test: _____ Date: _____ Test Location: _____ List Radiology Test: _____ Date: _____ Test Location: _____ **Please fax records pertinent to the referral diagnosis**
Requesting Physician	**Referring Physician Signature:** (Required for PT and diagnostic tests only) _____ (Signature) _____ (Date)