THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Patient Appointment/Consultation Request Form

Fax completed form to the Consultation and Referral Services Center at 913-588-5785.
For questions call 913-588-5862 or 877-588-5862 or visit kansashealthsystem.com/consult.

Part I – Referring physician information

Today's date: _____ Referring physician: _____

Practice name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Contact: _____ Office Phone: _____ Fax: _____

Part II – Patient information

Patient name: _____ DOB: _____

Last 4 digits SSN: _____ Gender: _____

Address: _____ City: _____ State: _____ ZIP: _____

Email: _____ Phone: _____ Alternate phone: _____

Interpreter needed? ☐ Yes ☐ No Specify language: _____

Insurance: _____ Guarantor: _____

Part III – Appointment information

Presenting diagnosis/problem: _____

_____

Is this a workers' compensation injury? ☐ Yes ☐ No

☐ Routine (next available appointment)

☐ Immediate/urgent

If immediate/urgent, please specify reason below. Medical records must be faxed for these requests.

_____

_____

☐ First available doctor ☐ Requesting specific physician: _____

Department/Specialty: _____

Part IV – Personal representative's contact information

(Complete only if the personal representative should be notified of the patient's appointments.)

Personal representative name: _____

Phone: _____ Relationship to patient: _____

By signing below, you, the patient, authorize the consulting physician's office to inform your personal representative named above of your appointment.

X _____

Signature of the Patient

Part V - Completed by The University of Kansas Health System and returned to referring office.

Appointment date: _____ Appointment time: _____

Physician name: _____ Location: _____