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:_____ Phone:_____ Fax:_____

Part II – Patient information

Patient name:_____ DOB:_____ Last 4 digits SSN:_____ Gender: M F

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

Home phone:_____ Cell phone:_____ Work phone:_____

Interpreter needed? Y N Specify language:_____

Insurance:_____ Guarantor:_____

Part III – Appointment information

Presenting diagnosis/problem:_____

- Is this a workers' compensation injury? YES NO
- _____ ROUTINE (next available appointment) YES NO
- _____ IMMEDIATE/URGENT YES NO

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

_____

Circle one: First available doctor/Requesting physician (if known):_____

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

Appointment date:_____ Appointment time:_____

Physician name:_____ Location:_____

Insurance referral must be faxed to 913-588-5785 before the appointment can be confirmed.