

**MO Telehealth Network - Dermatology Consultation Request Form fax to (573)884-0723**

*This form must be filled out completely before a Dermatology appointment will be scheduled.*

Site Name \_\_\_\_\_ Contact \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**CONSULTATION INFORMATION**

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_ Appt Date & Time \_\_\_\_\_

Nature of Request \_\_\_\_\_

Provider Seeking Consult \_\_\_\_\_ PCP Physician \_\_\_\_\_

Request opinion/advice regarding: \_\_\_\_\_

Dx: (if one was made) \_\_\_\_\_

History and Present Illness \_\_\_\_\_

\_\_\_\_\_

Has the patient been seen at University of Missouri Health Care before? YES NO

Does patient need an interpreter? YES NO If so, what language? \_\_\_\_\_

**PATIENT INFORMATION**

Street Address \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City, State and Zip \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

DOB \_\_\_\_\_ SSN# \_\_\_\_\_

If under 18, name of parent/guardian \_\_\_\_\_

Sex: Male Female Race: White Black Hispanic American Indian Asian Other

Marital Status: Single Married Spouse/Guarantor Name \_\_\_\_\_

In case of emergency, whom do we contact? Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE? (circle ALL that apply) Self-Pay Medicare Medicaid HMO PATOS POS/PPO Commercial

Does this Insurance require a referral? YES NO

Ins Co Name \_\_\_\_\_ Ins Co Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Ins Co Phone ( ) \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Patient Relationship to Subscriber \_\_\_\_\_

Subscriber's Gender: Male Female Subscriber's Date of Birth \_\_\_\_\_

Insurance Id # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Responsible Party's Name \_\_\_\_\_ SSN \_\_\_\_\_

Address of Responsible Party \_\_\_\_\_