

Missouri Telehealth Network -- Consultation Request Form fax to (573)882-5666

This form must be filled out completely before an 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 _____