THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

OUTPATIENT CONSULT REQUEST FORM

Patient Label Here
For UTMC Use Only

Please type or print/write legibly

Please fax this along with insurance information to the clinical area you are referring your patient. For questions about this form, call Physician Referral and Resources at 800-556-5444 or 419-383-4444.

To access this form online go to: utmc.utoledo.edu/patientguests/justforphysicians

To	Date _____ Referred to: _____ *(Specialty Clinic or Service)* _____ *(Physician Name)*	
From	Referring Physician: _____ *(Please Print)* Office Name: _____ Office Contact: _____ Phone #: _____ Fax # _____	
PCP *(If different from Referring Physician)*	Physician Name: _____ *(Please Print)* Office Name: _____ Office Contact: _____ Phone #: _____ Fax # _____	
Diagnosis and Reason for Consult or Therapy	**** Please fax the last office visit notes and any test results with this form.**	Appointment Requested: ☐ Next available ☐ Within 2 weeks ☐ Within 1 week ☐ Within 24 hours Other: _____ Second Opinion? ☐ Yes ☐ No
Patient Information	Name: Last _____ First _____ UTMC Registration # *(if available)*: _____ Gender: ☐ M ☐ F D.O.B.: _____ Phone: Home ( ) _____ Work ( ) _____ Other ( ) _____ Address: _____ City: _____ State: _____	
Insurance Information	Insurance: _____ ☐ HMO ☐ PPO ☐ POS ☐ Traditional ☐ Medicare ☐ Medicaid ☐ None Name of insurance plan, i.e., Medical Mutual, Medicare Advantage, etc. _____ Auto Accident? ☐ Y ☐ N Date of Injury: _____ Workers Comp? ☐ Y ☐ N Date of Injury: _____	
SELF PAY	**** Self pay patients are required to contact Patient Financial Services @ 419.383.4044 at the time an appointment is scheduled to arrange a payment plan.**	

APPOINTMENT SCHEDULED:

Dr. _____ Date of Appointment _____ Time_____

**** Patients will be contacted with the date of their appointment unless otherwise specified by the referring physician.**

☐ **Check here if you would like confirmation of date/time of the appointment. FAX NUMBER _____**