

Consult Services Request

PATIENT INFORMATION

Today's date:
Patient Name:
Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Best Contact Phone:
Interpreter Needed:

PHYSICIAN INFORMATION

Clinic/Specialist Requested:

<input type="checkbox"/> * Consult Question: (Diagnosis/Treatment/Surgical Opinion)
<input type="checkbox"/> * Transfer of Care Issue : (condition or problem the specialist is being asked to manage)

Diagnosis: (Reason for request)

PT.NO

NAME

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

CONSULT SERVICES REQUEST

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