UW
TELEHEALTH PROGRAM
Consult Request Form

To be completed by Referring Provider or Educator/Assistant/Site Coordinator. If possible, please fax the white Patient Information Request, UWMC Consent for Care, and UW Telemedicine Consent forms along with this form. Also, please include relevant patient history information, lab results, etc. which may be useful to the consultant prior to seeing the patient.

TODAY'S DATE: _____

NAME OF REFERRING PROVIDER: _____ LOCATION: _____

PATIENT'S NAME: _____ PATIENT'S SEX: M F PATIENT'S AGE:_____

HAS THIS PATIENT BEEN SEEN VIA TELEMEDICINE PREVIOUSLY? YES NO

WHAT IS THE SPECIALTY AREA OF THE DESIRED CONSULTANT? (BE AS SPECIFIC AS POSSIBLE) IF YOU KNOW THE NAME OF THE CONSULTANT YOU WOULD LIKE TO TALK WITH, PLEASE WRITE IT HERE.

PLEASE PROVIDE A BRIEF DESCRIPTION OF THE NATURE OF THE PROBLEM YOU WOULD LIKE THE CONSULTANT TO ADDRESS AND ANY SPECIFIC QUESTIONS YOU WOULD LIKE HIM/HER TO ANSWER.

_____

_____

_____

_____

WILL THE PATIENT BE PRESENT DURING THE VIDEOCONFERENCE WITH THE CONSULTANT? _____

WILL DIGITIZED IMAGES BE SENT FOR THE CONSULTANT TO VIEW? _____

IF SO, WHAT TYPE OF IMAGES AND HOW MANY OF EACH? (list number)

SNAPSHOTS: _____ XRAYS: _____ MRIS: _____ CT SCANS: _____ OTHER: _____

WE WILL ATTEMPT TO SCHEDULE TIME WITH A CONSULTANT AT THE EARLIEST AVAILABLE TIME WITHIN THE NEXT 10 BUSINESS DAYS ONCE THIS FORM IS RECEIVED.
DOES THIS PATIENT NEED TO BE SEEN SOONER? _____ IF SO, HOW SOON? _____

PLEASE LIST TIMES IN THE NEXT 10 BUSINESS DAYS WHEN YOU (THE REFERRING PROVIDER/EDUCATOR) AND THE PATIENT (IF APPLICABLE) WOULD BE AVAILABLE TO VIDEOCONFERENCE WITH THE CONSULTANT.

THE FOLLOWING ARE TO BE COMPLETED AFTER THE CONSULTATION:

ELAPSED TIME OF THIS ENCOUNTER (in minutes) _____

WHO WAS PRESENT DURING THIS ENCOUNTER: _____

WHAT TYPE OF SESSION WAS THE ENCOUNTER? EDUCATIONAL _____ MEDICAL _____

FAX this form and the additional materials requested above to
Sarah Dyck, Program Manager at:
(206) 616-4990 Questions? Call (206) 685-3676