Patient Name:

DOB:

MR #:

Index to Consult/Referral/Transfer
Date: _____
EPIC/UWHC#: _____

UW Health
(University of Wisconsin Hospitals and Clinics Authority)
REQUEST FOR CLINIC APPOINTMENT

For urgent appointment requests, please call the clinic directly.
This form may be used to request an appointment in any UW Health adult or pediatric specialty clinic.

Please provide all required (*) information. Missing information may result in delayed processing of this request.
We may contact the patient directly for additional information, please notify the patient of this appointment request.

Patient Information

Patient Name*: _____
Patient Address*: _____
Preferred Contact: ☐ Patient ☐ Parent/Guardian ☐ POA
☐ Other _____
Preferred Contact Name: _____
Primary Phone number*: _____

Date of birth*: ___/____/____
Sex*: ☐ Male ☐ Female ☐ X ☐ Nonbinary
City*: _____ State*: _____ Zip*: _____

Interpreter needed? ☐ No ☐ Yes Language: _____

Insurance Information

Name of insurance*: _____
Subscriber/Member/Employee ID #*: _____

Subscriber name*: _____
Group number: _____

***Please fax a copy of the insurance card with the request form if possible.**

Provider Information

Referring Provider Name*: _____
Clinic Name*: _____
City: _____
Primary Care Provider and Clinic :_____

Contact Person Within Your Clinic

Name*: _____
Phone #*: _____

Clinical question to be answered*: _____
Indication or Diagnosis*: _____
Specialty Clinic(s)/Procedure requested*(***signature required** for procedure): _____
_____

Physician/NP/PA requested:_____
Has the patient previously been seen by a specialist for this problem? ☐ Yes ☐ No
If yes, who did he/she see and date of last visit? _____

Related testing that has been done regarding the above diagnosis: _____
_____

Please include any medical records, reports, or test results which are pertinent to this referral

PLEASE FAX INFORMATION TO: (608) 203-2661 **TOLL FREE FAX #: (888) 875-8490**

For additional copies of this form go to uwhealth.org/referral

Referring Provider Signature: _____ Date: _____ Time: _____ Pager#: _____

This form is for use by non-UW Health providers