Mountaineer Doctor Television

Advanced Scheduling Telemedicine Consult Referral Request Form

Site Name: _____

Clinic Site Coordinator: _____

Phone: _____

Fax: _____

Referring Specialty: _____

Reason for Consult: _____

Explain the purpose of Evaluation: *(please include the full details to enable comprehensive evaluation)*

Site Coordinators: All information requested below is necessary for patient registration prior to scheduling.

___ Inpatient ___ Outpatient ___ New Patient Consultation ___ Follow-Up Consultation

Patient Information:

1. Patient Name: _____ Female ___ Male ___
2. Date of Birth: _____ SSN: _____
3. Address: _____ City: _____ Zip: _____
4. Telephone Numbers: Home:_____ Work: _____ Cell: _____
5. Marital Status: Married____ Single ____ Separated____ Divorced____
6. Employer Name: _____ Employer Phone #: _____
7. Have you ever been seen at this specialty clinic under another name? No___ Yes____
   If yes, what name: _____

Guarantor Information: ***(Complete this section ONLY if different from patient or if patient is under 18)***

8. Guarantor Name: _____ Date of Birth: _____ Relationship to Patient:_____
9. Address if different than patient: _____
10. Employer Name: _____ Employer Phone #: _____

Insurance Information:

11. Name of insurance: _____ Policy#: _____
12. Policy Holder's Date of Birth (if different from patient) _____
13. Authorization #: _____ Expiration Date: _____
14. What does the authorization cover and how many visits does it cover?

_____

(Please attach copy of insurance card and a copy of insurance authorization)

Policy Holder Information: ***(Complete this section ONLY if different from patient and Guarantor)***

15. Policy Holder Name: _____ Date of Birth: _____
16. Social Security Number: _____
17. Relationship to Patient: _____

Referring Clinical Information:

18. First and Last Name: _____ Telephone Number: _____
19. Street Address: _____ City: _____ State:____ Zip: _____
20. AMA License # _____
21. If referring clinician is not an MD or DO, please indicate supervising MD/DO Name: _____

(Please attach all pertinent Medical Records as specified on the referral guideline to this request for consulting specialist to review before patient is seen.)