UNIVERSITY OF FLORIDA PHYSICIANS

# PATIENT APPOINTMENT REQUEST FORM

TODAY'S DATE _____

**PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY**

Please choose one:

☐ **Consultation** (Requesting consultation for a specialty opinion which will be used by the referring physician in care management with or without co-management of care by the specialist.)

☐ **Referral/Transfer of care** (Requesting referral for specialty evaluation and subsequent management of a problem by the specialist alone)

Requested Specialty: _____

Physician Preference (if applicable): _____

Specific questions to be answered: _____

Signs/Symptoms/Dxs: _____

Notes from Requesting Clinic: _____

(attach label if available)

Patient Name: _____ DOB:_____ UF/Shands MR# _____

Home #:_____Work #:_____Cell #:_____

Authorization Information* (e.g. #, # visits allowed, expiration date): _____

* If Authorization is required, requesting physician/clinic must complete prior to appointment.

Please choose one:

☐ **Urgent: Name of the Provider you spoke with:**_____

If Urgent there must be a physician to physician call made by the requesting physician per UFP policy

☐ **Specific Time Frame: Routine: _____Days _____Weeks _____Months _____Other**

Please indicate when you would like appointment (next available, within 1 month, etc).

**Requesting Physician Information**

Name: _____ MD IDX #: _____

Attending Signature: _____