

SECTION OF THORACIC SURGERY

1500 East Medical Center Drive, 2120TC
Ann Arbor, MI 48109-0334
M-LINE: 1-800-962-3555
Phone: 734-936-4973 Fax: 734-647-8204

REQUEST FOR CONSULTATION

PLEASE COMPLETE FORM AND FAX TO 734-647-8204. Missing information may delay referral process.
Date Request: _____ Staff Name: _____ Phone #: _____

Section 1: Patient Information UM Registration #: (Internal use only) _____
Patient Name: (PLEASE PRINT) _____
Address: _____ City/State/Zip: _____
Sex: F ___ M ___ Social Security #: _____ Date of Birth: ___/___/___
Telephone #s: (home): (_____) _____ (work or cell): (_____) _____
Patient's Insurance (REQUIRED), please fax referral, if required, to 734-647-8204:
Name of Policy Holder: _____ Phone # of Ins Co: _____
M-CARE ___ BCN ___ BCBS ___ Medicaid ___ Other _____ HMO ___ POS ___ PPO ___

Section 2: Referring Physician Information (REQUIRED)
Physician's Name: _____
Address: _____ City/State/Zip: _____
Telephone #: (_____) _____ Fax Number: (_____) _____
UPIN Number: _____ UM Dr. Number (if applicable) _____

Section 3: (REQUIRED) Please provide a brief medical history including duration of symptoms and treatments tried.

Diagnosis:

Depending upon the patient's diagnosis, some of the following tests will be required. To avoid duplication of tests, please list relevant studies and date completed: Fax reports if not performed at UMHS.

ESOPHAGEAL
CT: chest date: ___/___/___ (within last 2 months)
CT: abdomen date: ___/___/___ (within last 2 months)
Barium Swallow date: ___/___/___ (within last 3 months cancer, 6 months benign)
Esophagoscopy/Bx date: ___/___/___ (within last 3 months cancer, 6 months benign)
Esophageal Function Study date: ___/___/___
PET date: ___/___/___
PFT/ABG date: ___/___/___
LUNG, MEDIASTINUM, PLEURAL
Bronchoscopy/Bx date: ___/___/___ (within last 3 months cancer, 6 months benign)
Chest Xray date: ___/___/___ (within last 3 months cancer, 6 months benign)
PFT/ABG date: ___/___/___

If the patient has had prior surgery on the chest or abdomen, please fax the previous op notes.

Other (List) _____

Please fax consultation request form and medical documentation to (734) 647-8204