CCHP SPECIALTY CARE SAFETY NET INITIATIVE

Live Video Telemedicine Consult Referral Request Form

◯ **UC Davis (D) Fax# (866)622-5944** ◯ **UC Irvine (I) Fax# (714)456-8466**

Site Name: _____

Clinic Site Coordinator: _____ Phone _____ Fax _____

◯ **New Patient Consultation** ◯ **Follow-Up Consultation**

◯ Adult Endocrinology (D) ◯ Pediatric Endocrinology(I) ◯ Adult Neurology (I)

◯ Pediatric Neurology (D, I) ◯ Pediatric Psychiatry (I) ◯ Adult & Pediatric Orthopedics (D)

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.

PATIENT INFORMATION:

1. Patient Name:_____ Female ◯ Male ◯
2. Date of Birth:_____SSN:_____Ethnicity:_____
3. Address:_____ City:_____Zip:_____
4. Telephone Numbers: Home_____ Work_____
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, under 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 CLINICIAN 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.)