UF& Shands Jacksonville
The University of Florida Academic Health Center

PATIENT APPOINTMENT REQUEST FORM
****EXTERNAL ONLY**

TODAY'S DATE _______________

Clinic or Service to which you are referring a patient:

____

Physician Preference (if applicable): ____

☐ **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)

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

PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY

Patient Name: ______________________ Authorized Contact Person (if different from Pt.):______________________

Patient's Social Security Number: ________________ DOB: ____________ UF/Shands MR# ________________

Mailing Address: _________________________________ City: __________________ State:________Zip:_________

Preferred Phone No.: ______________________________ Alt. No.:____

Insurance Company: ______________________________ Ins. Co. Phone Number:___________________________

Policy/ID #: ________________ Group #:___________________ Employer: ______________________

If patient is a child, it is **REQUIRED** to include Guarantor/Guardian Information

Subscriber/Guarantor Name: ___________________________ Subscriber/Guarantor DOB: _____________________

Subscriber/Guarantor SS#: _______________________ Subscriber/Guarantor Phone No.: ______________________

Subscriber/Guarantor Address: __________________________________ Relation to Patient: __________________

Authorization Info*: Auth. # __________________ # Visits Allowed ________ Expiration Date ____________________

*If Authorization is required, referring physician/clinic must complete prior to referral.

Requesting Physician Information

Name: ____ Specialty: ____

NPI: ___________________________________

Mailing Address: _________________________________ City: __________________ State:________Zip:_________

Phone Number: ________________ Fax Number: __________________ Contact Person: __________________

Person completing form: ____

Would you like to see the patient back in follow-up? ☐ **Yes** ☐ **No**

Primary Care Physician Information ☐ Same as above (If different, please complete below)

Name: ____

Mailing Address: _________________________________ City: __________________ State:________Zip:_________

Phone Number: ________________ Fax Number: __________________ Contact Person: __________________

Reason for Appointment (Required):

____

____

Studies / Procedures requested: ____

Diagnosis/Problem/ICD-9: ____

Medications currently on:

____

____

All applicable clinical notes, recent lab work, radiological interpretations, copies of front and back of insurance cards, and any other pertinent information should accompany this request.

PRINT COMPLETED FORM AND FAX TO 904 383-1075 (TOLL-FREE 855 383-1075)