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PATIENT CONSULT REQUEST FORM

ALL ITEMS MARKED WITH (*) ARE REQUIRED.

REFERRING PROVIDER INFORMATION*

PERSON COMPLETING THIS FORM: NAME: _____ PHONE#: _____

PATIENT AWARE OF CONSULT REQUEST? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____ FAX #: _____

REFERRING PHYSICIAN (IF OTHER THAN PRIMARY): _____

REFERRING FACILITY NAME: _____

REFERRING FACILITY PHONE #: _____ REFERRING FACILITY E-MAIL ADDRESS: _____

IPA/MSO (IF APPLICABLE): _____

PATIENT INFORMATION

IS THE PATIENT'S PCP AWARE THAT MEDSOURCE CONSULTANTS WILL BE CONTACTING THE PATIENT FOR TREATMENT?

☐ YES ☐ NO

PATIENT NAME*: _____ D.O.B. *: _____

PATIENT ADDRESS*: _____ CITY: _____ STATE: _____ ZIP: _____

PATIENT PHONE*: _____ PATIENT EMAIL: _____

CAREGIVER/FAMILY PHONE*: _____ CAREGIVER/FAMILY EMAIL: _____

CURRENT LOCATION OF PATIENT: _____

PATIENT LOCATION: ☐ SNF/ALF ☐ HOME

ELIGIBLE INSURANCE INFORMATION*

DATE OF REFERRAL*: _____ MEDICARE NUMBER*: _____

NAME OF HEALTH PLAN: _____ PLAN TYPE: _____

MEMBER ID: _____

REASON FOR REFERRAL

CPT CODE*: _____ WOUND LOCATION*: _____

WOUND TYPE: ☐ ARTERIAL ☐ DIABETIC ☐ PRESSURE ☐ SURGICAL ☐ TRAUMA ☐ VENOUS

☐ OTHER: _____

Consult Request from PCP: include patient face sheet/demographics and pertinent medical records.

Consult Request from Home Health/ SNF: include patient face sheet/demographics, patient skilled authorization number (if Part A), physician order and pertinent medical records.

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