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REFERRED TO: ☐ **Provider:** ☐ UWMC ☐ HMC ☐ CHMC ☐ OTHER:		DATE
PROVIDER NAME **(PLEASE PRINT)**	PATIENT NAME **(PLEASE PRINT)**	
SPECIALTY/SERVICE	ADDRESS	
ADDRESS	CITY/STATE	
CITY/STATE ZIP	TELEPHONE NUMBER ZIP	
TELEPHONE NUMBER	APPOINTMENT/ADMIT DATE	APPOINTMENT DATE

REASON FOR CONSULTATION: ☐ Opinion Only ☐ Assume Charge of Aspect of Patient ☐ Assume Charge or Transfer Patient

Primary Diagnosis:

Diagnosis That Suggests Consult:

Pertinent History and Physical:

REFERRED BY: ☐ **Provider:** ☐ UWMC ☐ HMC ☐ CHMC ☐ Other:	DATE
PROVIDER NAME **(PLEASE PRINT)** **UPIN**	DATE RETURNING TO REFERRING CLINIC
SPECIALTY/SERVICE	☐ INTERPRETER
ADDRESS/MS	
CITY/STATE ZIP	☐ PLEASE **NOTIFY** REFERRING PHYSICIAN WHEN APPOINTMENT HAS BEEN SCHEDULED.
TELEPHONE NUMBER	

PT.NO

NAME

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

PROFESSIONAL CONSULTATION REQUEST

U0455

UH0455 REV DEC 05

WHITE – MEDICAL RECORD
CANARY – CONSULTING SERVICE
PINK – REFERRING PHYSICIAN

PROGRESS – **BLUE**