Reset this form

Please print and fax completed form to 206-598-5876.
If you are using ADOBE ACROBAT READER, you cannot save the text you enter below.

Print this form

REFERRED TO: ☑ **Provider:**
☐ UWMC ☐ HMC ☐ CHMC ☑ OTHER: Bone & Joint Surgery Center

DATE

PROVIDER NAME (PLEASE PRINT)	PATIENT NAME (PLEASE PRINT)
SPECIALTY/SERVICE UW Orthopaedics and Sports Medicine	ADDRESS
ADDRESS 4245 Roosevelt Way N.E., 2nd Floor; Box 354740	CITY/STATE
CITY/STATE ZIP Seattle, WA 98105	TELEPHONE NUMBER ZIP
TELEPHONE NUMBER Phone: 206-598-4288 Fax: 206-598-5876	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	☐ PLEASE **NOTIFY** REFERRING PHYSICIAN WHEN APPOINTMENT HAS BEEN SCHEDULED.
CITY/STATE ZIP	
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**