UF | Department of Medicine
UNIVERSITY of FLORIDA

APPOINTMENT REQUEST FORM

FAX TO: 352-627-4179

Clinic or Service to which you are referring a patient: Today's Date: _____

☐ Cardiology ☐ Endocrinology ☐ Gastroenterology ☐ Hep/Liver Tx ☐ Hematology ☐ Heart Transplant ☐ Infectious Diseases

☐ Lung Transplant ☐ Mycobacteriology ☐ Nephrology ☐ Pulmonary ☐ Renal Transplant ☐ Rheumatology ☐ Allergy

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.)*

Current Diagnosis: _____

Reason for Appointment (Required): _____

_____

Patient Name:_____ Patient DOB: _____

Authorized Contact Person (if different):_____

Mailing Address: _____ City:_____ State:_____ Zip: _____

Preferred Phone Number:_____ Alt. Phone Number:_____

Insurance Company: _____ Ins. Phone Number: _____

Policy/ID #: _____ Group #: _____ Policy Holder Name:_____

Employer:_____ Authorization Information (#, visits, expiration):_____

(If authorization is required, referring physician/clinic must complete prior to referral.)

Physician Requesting the Appointment

Name: _____ Specialty:_____

Mailing Address: _____ City:_____ State:_____ Zip: _____

Phone Number: _____ Fax Number: _____

Primary Care Physician ☐ Same as Above (If different, please complete below.)

Name: _____ Phone Number: _____ Fax Number: _____

Mailing Address: _____ City:_____ State:_____ Zip: _____

Please see page 2 for a list by specialty of applicable clinical notes, recent lab work, and radiological interpretations that should be sent with this request.

Please include copies of front and back of insurance cards and any other pertinent information.

Thank you for referring your patient to the University of Florida. All of our specialties require specific information in order to schedule your patient with our clinic. Please make sure the following records are included for the physician's review:

Cardiology- H&P, most recent images and reports for EKG, cardiac catheterization, stress test, event monitor report WITH EKG strips, copy of EP study or ablation on CD (if applicable), echo, Op reports, recent hospital discharges, and most recent lab work.

*If patient is on Coumadin, we need a copy of last four INR's

Endocrinology- 3-6 months of office notes, testing and labs appropriate for diagnosis:

***Adrenal Mass:** Renin & Aldosterone/Catecholamines & Metaphrines/24 Hr creatinine & Cortisol/Dexamethasone suppression test results (if available)/CT of adrenal glands

*** Diabetes**: HBA1C (Greater than 7.0)/CBC/Fasting Lipid Panel/CMP/Microalbumin

*** Hirsutism**: Testosterone/LH/FSH/Estrogen/Sex-hormone binding globulin/Androstenedione/Serum cortisol/Prolactin/IGF-1/FREE T4/TSH

*** Hyperthyroidism**: TSH/FREE T4/TOTAL T3

*** Hypothyroidism**: TSH/FREE T4

*** Parathyroid/Osteoporosis**: PTH Intact/24 HR Urinary calcium/CMP/Phosphorus & Creatinine/vitamin D/serum protein electrophoresis/DEXA scan

*** Pituitary**: Serum cortisol/Sex hormone binding globulin/Prolactin & ACTH-IGF-1/FREE T4/TSH/24 hr urine for cortisol & cratinine/random urine for specific gravity/osmolality & serum osmolality.

MEN: Testosterone levels WOMEN: LH/FSH/Estrogen levels

* **Thyroid Cancer:** TSH/FREE T4/Thyroglubulin & Antibodies/Pathology of thyroid biopsy

* **Thyroid Nodule**: TSH/FREE T4/TOTAL T3/Thyroid ultrasound (Must be greater than 1 cm)

Gastroenterology- 3-6 months of office notes, recent hospital discharges, and testing appropriate for diagnosis (colonoscopy/endoscopy)

Hepatology/Liver TX- 3-6 months of office notes, recent hospital discharges, CT scan/US, liver biopsy, testing appropriate for diagnosis, and recent lab work

Heart TX - Please fax office notes and appropriate testing to 352-265-0556

Infectious Disease-3-6 months of office notes, recent hospital discharges, testing appropriate for diagnosis, and recent lab work (HIV patients must have western blot or confirmation of HIV diagnosis)

Lung TX-Please fax office notes and testing to 352-265-8970

Mycobacteriology-3-6 months of office notes, recent hospital discharges, pulmonary testing reports, & all microbiology lab reports

Nephrology- 3-6 months of office notes, recent hospital discharges, testing appropriate for diagnosis (kidney or abdominal ultrasound, abdominal/pelvic CT scans or MRIs, renal Doppler or duplex studies, kidney biopsy reports), and recent lab work

Pre-Kidney TX-Please send office notes and appropriate testing to 352-265-0084

Post-Kidney TX-Please send office notes, test results, and transplant information to 352-265-8244

Pulmonary- Last 2 office visits, pulmonary function test (including 6 minute walks), lung pathologies, all chest CT and x-ray reports (patient must bring disk with them to appointment), and echo report (if available). In addition, please send the following for these diagnoses:

***Alpha 1**-Alpha 1 Anti trypsin level and genetic testing

***Bronchoscopy**-reports of previous bronchoscopies

***Cystic Fibrosis**-sputum culture results, results of genetic testing, previous records related to CF

***Pulmonary Hypertension-**records of previous right heart cath. (if done)

***Sleep diagnosis**-copy of previous sleep studies

Rheumatology- 3-6 months of office notes, recent hospital discharges, medication list, recent labs studies

***Autoimmune diagnosis'** MUST include CBC w/ DIFF/ESR/RF/ANA)