Provider's Guide to Referrals/Consult Forms in the AFHCAN system (3/4/2014)

The following document is intended to help identify what elements are needed for a complete request fo referral or consultation to the ANMC Specialy Clinics using the AFHCAN tConsult system. Nearly all forms require the Referring Provider's name, credentials, and NPI number, as well as the name/phone of the individual completing the form

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
Cardiology	Request for Referral	Reason for referral	History and Physical
		Seen by ANMC Cardiology past 3 yrs? If yes, which clinician?	EKG
			Medication List
			Recent Labs
			CXR*
Comprehensive Pain Management Center	Request for Evaluation and Consultation	Reason for request for evaluation and consultation	Comprehensive Pain Management Pain Questionnaire completed by patient
		Location of pain	MRI
		Date of injury or onset of pain	CT
		Type of injury	EMG/NCS
		Previous treatments (i.e. exercise program, surgery, medication, injections, behavioral therapy?)	Xray
		Does the patient currently have, or have they ever had a pain contract?	Other (if done)
		If so, where?	
		Has there been a breach of contract?	
		If applicable, specific injection being requested?	
Dental	E-Referral Non ASU Field Referral	Patients future travel plans	Dental Records
		Significant Medical History	X Rays
		Current Medications	Related Treatment Notes
		Diagnosis	Current Medical History
		Is Patient Symptomatic? Yes/No	Copy of Social Security Card
		Summary of Requested Services and Pertinent Information	Copy of Birth Certificate
		What ASU Services are requested: Prosthodontic (ASU patients only), Crowns/Bridges, Full/partial dentures	Tribal Card or Certificate of Indian Blood (blood quantum noted)
		NON-ASU Services requested: Pediatric Dentistry, Oral Maxillofacial Surgery, Endodontic (fees will apply)	Completed Patient Registration Worksheet
		If the requested procedure is preprosthetic surgery, is there a current prosthetic treatment plan? Yes/No	
		For Endodontic Services, tooth number	
		For Endodontic Services, if retreatment, date of first treatment	
		For Endodontic Services, how do you plan to restore the tooth after completion of endodontic treatment?	

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
Dermatology	Dermatology (General)	Reason for consult with symptoms Duration and progression of symptoms Location(s) on body Current medications or in past 3 weeks Drug Allergies Brief history (narrative)	Photo: Close up image Photo: Regional view with anatomic landmark Photo: Side view for height and surface
Dermatology	Dermatology Appointment Request	Brief description of the problem Medication List Patient Travel Needs (housing, escort, etc)	Images
Diabetes	Diabetes Consult	Chief Complaint and current question/issue How long has the patient had diabetes? Do you have a blood glucose record? Yes/No History of MI, Stroke, or CKD? Other Pertinent History; Smoker, Alcohol use: approximate amount and frequency, BP, P, BMI or weight, Other Exam Questions	Scanned Lab Report or A1c, Cr, CBC, Lipids, ALT, and Glucose If Foot question, please include foot exam including microfilament and photographs
Endocrinology	Follow-up after Iodine 131 for Hyperthyroidism	When was patient treated with Iodine 131 Current Medications (including contraceptives) Inj, IUD, Tubal Ligation, Oral Contraceptive, Other (describe) Weight loss over 5 lb in past 2 months? Weight gain over 5 lb in past 2 months? Frequently feels too hot? Frequently feels too cold? Frequent heart palpitations? Constipation? Muscle and joint aches and pains? New onset or Chonic? Other complaints/concerns (describe) abnormal, describe): General appearance (describe); Weight, Eyes, Neck, Chest, Heart, Abdomen, Neuro, Skin Any other concerns for Endocrinologist to Address?	Lab reports with TSH, free T4, Any other pertinent lab data

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
Endocrinology	Thyroid Concerns (Hyperthyroidism, Hypothyroid, Nodule, etc)	Patient's chief complaint History of Present Illness Propylthiouracil (PTU)? Methimazole? Levothyroxine? Other thyroid medications? Has patient ever had a thyroid scan/update? If yes, date, place, findings (if known) Has patient ever received Iodine 131 treatment? If yes, date, place findings (if known) Has patient had a thyroid ultrasound? If yes, date, place, findings (if known) Has patient had a thyroid biopsy? If yes, date, place, findings (if known) Has patient had thyroid surgery? If yes, date, place, findings (if known) For female patients only, date of last menstrual period Is patient pregnant?	
ENT	ENT Direct Referral Appointment Form for Tonsillectomy	Diagnostic criteria for direct referral (select below): distinct episodes with positive cultures or RST in a 12-month period of exudative tonsillitis (not pharyngitis) in a 12-motn time period, 5 or more episodes for two consecutive years or 3 abscess, febrile seizures, abscessed lymph nodes, or acute airway obstruction. Repeat episodes of severe tonsillitis adenoid hyperplasia. This may be manifested by chronic mouth breathing, nasal obstruction, severe snoring, apnea, If no on any of the following, patient should be referred to ENT clinic for evaluation: Preexisting medical problems that might complicate anesthesia delivery and/or the surgical procedure? Procedure requested in next four weeks? Does patient desire direct referral for surgery without regional clinic eval? Enlarged tonsils on exam?	
ENT	ENT Direct Referral of Other ENT Problems	Please describe the ENT problem you would like us to evaluate. Significant Medical History that may be related to ENT issue.	

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
ENT	ENT Ear Tube Request	tympanostomy tube placement in an otherwise healthy child. Patients meeting these criteria can be directly documented and separate AOM episodes in the past 6 months OR at least 4 well documented and separate AOM that is present for at least three months. Documentation of hearing loss or abnormal tympanometry is preferred when Pertinent History might complicate anesthesia delivery and/or the surgical procedure? Does patient desire procedure in next four weeks? Does patient desire direct referral for surgery forgoing evaluation in regional clinic? Pertinent Information disease may be considered on a case by case basis by the otolaryngologist retraction pockets should have a telemedicine case which includes images of the Tympanic Membrane sent to ENT other developmental delays, or other sensory deficiencies may be candidates for ear tubes with less stringent criteria. intervention must be individualized for each patient. Patients with ear or hearing problems not meeting these	In cases of severe retractions or retraction pockets, send images of the tympanic membrane sent to ENT.
ENT	ENT Direct Referral for Sinus CT Scan & Evaluation	and an ENT evaluation at ANMC. These guidelines are meant to facilitate the evaluation and treatment of distinctive infections in a twelve-month period. A diagnosis of sinusitis should be supported by at least two of the medical therapy consisting of at least one month of beta-lactamase resistant antibiotic therapy. Preferably, patients List antibiotics used including starting date and duration List nasal sprays used and duration prolonged signs and symptoms (primarily chronic sinusitis patients) should receive maximal medical therapy with recommendations will be made and communicated to the patient and referring provider. Patients should understand	

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
GYN Oncology	GYN Oncology	Symptoms / chief complaint Reason for referral Current medications / frequency / dose Pertinent H&P Interventions / results list any pre-existing conditions Additional Information: Gravida, Para, LC ? Smoker/Chew? ETOH?: None/past/current BMI (or current weight in lbs & kg + current height)	Labs* X-Ray* CD Disc of Radiology* CT Abd/Pel w/ contrast* Pelvic Ultrasound* Colonscopy* PAP* Biopsy* Pathology Report* Immunization History*
HIV/EIS	HIV EIS Consult	Description of problem Date of HIV diagnosis by opportunistic infection? Unknown ? HIV + reported to State Epi? AIDS reported to State Epi? Date/reason for AIDS diagnosis Risk factors for HIV: Heterosexual? MSM? IVDU? Perinatal? Transfusion? Unknown? Brief History: include any opportunistic infections, co-morbid conditions, etc. Prenancy status / contraception Hepatitis status (Hep C chronic; Hep C resolved; Hep B carrier; Hep B immune) Current HIV meds/doses/start date and prophylactic meds Adherence issues Other meds/doses List any HIV medications EVER taken Immunization History (dates of administration/immunity) Previous HIV history and pertinent medical history from past providers (include name and contact info for provider) or a reply to a sent case has not been received within the usual and expected time period, please call our main	CD4 (last 3) Viral load (last 3) Genotype (attach/list all previous and current resistance mutations) Phenotype Tropism CBC* CMP* Urinalysis* Renal function panel* Lipid Panel* STD screen (oral, rectal, urine)* RPR* CMV AB IGG* Toxoplasma AB IGG* Chronic Hep (A,B,C) screen HBVsAB* HLA B-5701* Cervical PAP* Anal PAP* TB Screening* Dental Screening* Ophtho screening (dilated)* Mental Health Screening* Substance abuse screening*

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
HIV/EIS	HIV EIS Referral	Description of problem Date of HIV diagnosis HIV status (HIV + asymptomatic; AIDS by CD4<200; AIDS by opportunistic infection; unknown) Reporting to State (Unknown, HIV reported to State Epi; AIDS reported to State Epi) Brief History: include any opportunistic infections, co-morbid conditions, etc. Current HIV meds/doses/start date and prophylactic meds Other meds/doses List any HIV medications EVER taken	CD4* Viral load* Genotype (attach all)* Other (if done)*
Internal Med	Back/Neck Pain Referral Request	Has this patient had prior back/neck surgery Prior Epidural Steroid Injections (ESI)? How many times? Beneficial? Accupuncture? Massage? Chiropractic Care? Other? List duration. Pain? Other? Location of neurological symptoms (right upper ext.; left upper ext.; right lower ext.; left lower ext.) MRI of affected area? Date of most recent. Patient claustrophobic? If yes, anti-anxiety medication must be prescribed by primary care provider. Any metal in body/worked with metal/gotten metal in eye? Patient over 350 pounds?	
Internal Med	E-Consultation	Endocrinology; General Int Med; Nephrology; Neurology; Rheumatology. Symptoms / chief complaint Reason for referral Current Meds: Frequency AND dose Pertinent H&P Interventions / results Does patient need escort? Does patient use Oxygen at home? If yes, attach escort request form	Supporting Studies done and date provided: labs, Xrays, CT, MRI, Ultrasound

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
Liver Clinic	Hepatitis C Referral	Patient Ht, Wt, BMI (include units) Past Medical History Medications (including OTC) Psychiatric History/Diagnosis (please list) Substance Abuse History: Alcohol? If yes, drink type/amount, frequency; Addiction treatments? Dates of treatment. Injection drug use? If yes, date of last injection drug use. Prescription drug abuse? If yes, date of last abuse. Audit-C Score (see Audit-C Tool in forms) Symptoms/abnormal findings (please list) Questions/areas of concern (please list)	Pertinent labs, imaging (US, CT)
Liver Clinic	Liver Clinic Referral - Not Hepatitis C	Patient Ht, Wt, BMI (include units) Past Medical History Medications (including OTC) Alcohol? If yes, drink type/amount, frequency Family History of liver disease? Symptoms/abnormal findings (please list) Questions/areas of concern (please list)	Lab Form 2 (Not Hepatitis C) Pertinent labs, imaging (US, CT)
Maternal Fetal Medicine	Maternal Fetal Medicine Form	Reason for referral/consultation Indicate any labs that are NOT included and why Additional pertinent information	Prenatal Flow Sheet Prenatal History - ensure at least month and year of all deliveries, TABs, and SABs are on record and legible Ultrasound report Prenatal visits PAP Report If Previous C/S - Operative report If patient desires BTL - Consent form HGB/HCT (hemoglobin)-CBC; GC; Clamydia; RPR; HIV; Glucola or 1hr GTT; 3hr GTT; CCUA or UA Micro; Blood Immunization Record On the prenatal flow record: PPD Placement and reading; HEP B Vaccine x 3; TD Immunization Date

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
Neurosurgery	E-Consult/Referral: Neurosurgery	Area of Concern: Head; Upper Spine; Lower Spine; Other (fill in box) Do you have MRI capabilities? Massage? Surgery? Other? Duration and outcome of intervention. Meds/Duration/Dose/Pain level with Meds/Pain level without meds H & P	Any pertinent studies / images including x-ray, MRI, CT, etc., (include where done and date)
Ophthalmology	Request for Evaluation and Treatment	Seen by ANMC Ophthalmology in the past? If yes, which provider? Please indicate affected area: Right, Left, or Bilateral? duration, date of last eye exam, current visual acuity, and family history)	Images* Labs* Patient history/notes* Medication List*
Orthopedics	Request for Evaluation and Consultation	Refer back pain cases to Neurology Reason for request for evaluation and consultation Injury is: New? Request for f/up to existing condition? Congenital/Genetic? Chronic? Acute? Location of Injury: Right, left, bilateral, NA Specific info regarding injury or complaint, method of injury, symptoms & diagnosis:	Current Patient History/Past Relevant history Medication List Imaging Reports Images sent via Teleradiology Images mailed to the Surgery Clinic Images sent with patient (when emergent case arriving immediately at ANMC)
Pediatrics	Pediatric Field Health/Specialty Care Coordination	Neurology; Pulmonary; Rheumatology; Speech-Language Pathology; Other (please specify) Procedures or services needed (provider orders) or information, patient history with pertinent dx and symptoms (scan in additional documents if needed)	
Podiatry	Podiatry Consult Request	Brief History Diabetic Patient?	Images* Other as needed*

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
Pulmonary Medicine	Referral Form (General Pulmonary Referral Form)	Seen by Pulmonary in past? Seen by? Spoke to which Pulmonologist about Patient? Reason for Referral Patient on oxygen? Shortness of Breath? Productive cough? Unproductive cough? Chest pain? Night sweats? Weight loss? Other? COPD, Empysema, Obstructive Sleep Apnia, Pneumonia, Asthma, Intersitial Lung Disease, Lupus, Connective Tissue Other Medical history: Thoracic Surgery History: Tobacco history: Current smoker, past, current smokeless tobacco, past, second hand smoke, None? Pack of cigarette/smokeless tobacco per day and pack/can years: Year quit tobacco use:	CT Thorax without contrast* AFB Sputums x 3* Chest Xrays* Bloodwork* Bronchoscopy* Pulmonary Function Tests* CT Guided Needle Biopsy* Other* Please telerad all Chest Xrays and/or CT Scans of Chest to ANMC Radiology or FedEx them
Pulmonary Medicine	Latent TB Referral Form	Reason for referral Date started treatment Location of treatment Exposure to TB: Year and By Other	
Pulmonary Medicine	Pre Op Clearance for Internal Medicine	Pulmonary Disease? COPD, Past Smoker, Current Smoker, Asthma, Obstructive Sleep Apnea, Other: Surgery: Date of surgery: Last PFT's (within last 6 months) If NO PFT's in last 6 month order: Full PFTs Pre and Post Spiro 6 min walk for distance 6 min walk for ex ox 6 min walk for titration Notes:	
Pulmonary Medicine	Sleep Clinic Referral Form	Pt. seen / reviewed by: Dr. Wurth; Dr. Madhani-Lovely; Dr. Wells Orders: Pre-Screen by Sleep Clinic Provider before schedule; Home Sleep Study; Titration study Other notes:	

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
Pulmonary Medicine	Sleep Laboratory Referral Sheet	BMI tracheostomy? Pain? Hypoventilation? CVA? TBI History? Narcotics? ESRD? COPD (What is the FEV?): CHF (What is the EF?): Other: to restroom, Dry mouth, Sleep paralysis, Excessive daytime sleepiness, Insomnia, Itching or tingling of legs, Depression, Toilet? Interpreter? Uses O2 continous? Uses O2 Noctural only? Pertinent Info to aid in treatment of this patient:	Medication List
SCF	SCF OB Transfer Prenatal	Reason for Transfer Indicate any labs that are NOT included and why Additional pertinent information	Prenatal Flow Sheet Prenatal History - ensure at least month and year of all deliveries, TABs, and SABs are on record and legible Ultrasound report Prenatal visits PAP Report If Previous C/S - Operative report If patient desires BTL - Consent form Clamydia; RPR; HIV; MSAFP or Quad Screen; Glucola or 1hr GTT; 3hr GTT; CCUA or UA Micro; Blood Type; Initial Immunization Records On the prenatal flow record: PPD Placement and reading; HEP B Vaccine x 3; TD Immunization Date
Sleep Studies Lab	Sleep Laboratory Referral Sheet	BMI tracheostomy? Pain? Hypoventilation? CVA? TBI History? Narcotics? ESRD? COPD (What is the FEV?): CHF (What is the EF?): Other: to restroom, Dry mouth, Sleep paralysis, Excessive daytime sleepiness, Insomnia, Itching or tingling of legs, Depression, Toilet? Interpreter? Uses O2 continous? Uses O2 Noctural only? Pertinent Info to aid in treatment of this patient:	Medication List

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
Surgery	Mayo Clinic Breast Cancer Collaboration Form	Reason for consultation: Family History, Hx atypical hyperplasia, Hx LCIS, Hx DCIS, Med Side Effects, Other: Review of symptoms (check all that apply): Hot flashes; night sweats; vaginal dryness; irregular vaginal bleeding pressure; diabetes; tobacco use; heart disease; irregular heart rhythm; blood clots; osteoporosis; other cancers Date of last mammogram: Breast ultrasound performed? Date: Biopsy performed? Date of pathology report attached: Bone mineral density study performed? Date: Date of last pap smear: Gail Model Risk 5 year: % Gail Model Risk Lifetime: % Counseling: High risk pt: 1-12; Atypia: 1-10; LCIS: 1-10; DCIS: 1-10 Recommendations: Lifestyle modifications Continue routine yearly mammogram or earlier diagnostic study per surgeons recommendation Tamoxifen 20 mg per day 3-month supply 4 refills Counseled patient to stop tamoxifen if they are sedentary (ie surgery, prolonged bed rest or traveling on airplane for >6 hours) and resume medication when back to usual Raloxifene 60 mg per day 3 month supply 4 refills Phone follow-up 4 to 6 weeks Clinical breast exam with primary care provider in ?? Months Bone mineral density study ?? Months (1-2 yrs) Pap smear date months ?? Months (2-3 yrs) Other	
Surgery	Surgery Clinic E-Consultation Form	Reason for requesting consultation/chief complaint: Relevant past medical history Medication list Additional pertinent information	Imaging Reports (if applicable) Images sent via Teleradiology (if applicable) Images mailed to the Surgery Clinic on CD (if applicable)

Service	Form name	Information Provider needs to fill in	Documentation/Labs/PreWork/Etc (* if optional)
Surgery	Wound Assessment Consultation	Wound location: Other wound info: History relevant to wound: Pressure Ulcer Stage: I-IV; DTI (Suspect deep trauma); UNS (unsure, unspecified) Size: (cms) LxWxD Sinus tract/tunneling? Location/amount (cms): Undermining? Location/amount (cms): Exudate: Serous; Seroussanguinous; Purulent. Amount: None; Small (1-33%); Moderate (34-66%); Large (67-100%) Granulation Tissue: Red; pink; pale. Amount: None; Small (1-33%); Moderate (34-66%); Large (67-100%) Yellow Slough/Fibrin: None; Small, Medium; Large Black Necrotic Tissue: None; Small, Medium; Large Exposed Tendon? Exposed bone? Periwound tissue: Macerated? Intact? Warm(above normal)? Necrotic? Indurated? Purple? Rolled? Periwound tissue: Dry? Mottled? Flaking? Scarred? Hyperpigmented? Callused? Edges Irregular? Erythema (cms): Odor? Epitheliazation? Wound Outcomes: Healed (epithelial tissue); Surgically closed; Grafted Healed; Grafted w/Partial Take Other: Pain level before dressing change (1-10): Wound care cleanser: Topical application: Antibacterial; Enzymatic Debrider; Hydrogel; Other (list) Wound Packing: Algniate; Silver Petrolatum; Foam; Gauze; Other (list) Wound Cover: Film; Foam; Gauze; Hydrogel Hydrocolloid; non-adherent; other (list) Periwound Prep? Pain level after dressing change (1-10): Additional comments: Negative Pressure Wound Therapy: Foam; Pressure; Periwound Prep	
Urology	Urology Clinic Consultation Form	Reason for requesting consultation/chief complaint: Relevant medical history: Media Sent (via Telerad)?	Supporting Studies (check appropriate): labs, Xrays, CT, MRI, Ultrasound