Alaska Native Medical Center
Request for Evaluation and Consultation

Date of request	
Date sent	
# of pages	

To: Clinic Name: _____ Fax: _____ Previously seen by / requested consultant:_____

From: Clinic Name: _____ Fax: _____ Village:_____Fax: _____

Pt's current location: ☐ Clinic ☐ Home ☐ Quyana House

☐ Hotel name _____ ☐ Inpatient ward _____, est. discharge date: _____

Requesting Provider: _____ Phone/pager: _____ Dates in ANC:_____

Requesting Provider Case Manager: _____ Phone/pager: _____ ☐ Patient requests consult / second opinion

Reason for the request to include specific questions or information, patient history with pertinent DX and symptoms:

_____

_____

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_____

Consultation /Tx Guidelines met? ☐ Yes ☐ No ☐ Guidelines not available

If no, Instructions from & name of consultant:_____

Oncology referrals only	
Staging	Pathology
"ER/PR" & "Her 2 Neu" result	Imaging studies & place

Please check information included: ☐ PCC+ ☐ PCIS ☐ Tx plan/Progress Notes ☐ Labs ☐ Discharge Summary

☐ Initial or updated intake ☐ Other _____ ☐ Tests Pending: _____

Primary Care Provider:_____ **Direct Phone/pager:**_____ **Date/time consultant appt:** _____

REQUESTING PROVIDER SIGNATURE:_____ ***required for processing***

Form must be faxed for all referrals. In addition, telephone calls must be made for referrals involving Family Medicine, Women's Health, Oncology, Behavioral Health, Complementary Medicine, Pediatrics, Internal Med., ENT, Audiology, Orthopedics, Surgery, Urology and Radiology. Telephone number for referrals: 729-8030

Patient Name		***QA to be completed by Consultant clinic***		
		Guidelines used appropriately	Yes☐	No☐
Parent/legal guardian, if applicable:		Referral Process Followed	Yes☐	No☐
		Adequate Information Provided	Yes☐	No☐
DOB/Chart #	Age	***QA to be completed by referring Provider clinic***		
		Referral Process Followed	Yes☐	No☐
Contact Phone #	Cell Phone #	Appointment Booked	Yes☐	No☐
		Dictated consultation summary received	Yes☐	No☐

Approved by MRC- 9/14/04