CONSULT REQUEST

Referring Provider: _____ NPI#: _____

Referring Clinic:_____

Phone:_____Fax:_____

Patient Name: _____

DOB: _____ Sex: Male Female

Phone: _____ Social Security #:_____

Specialty Care Type: _____

Diagnosis/Reason for referral: _____

_____

_____

Number of visits requested by referring provider: _____

Provider Signature:_____ Date: _____

***All Referrals MUST be accompanied by associated medical records, including relevant clinic notes, imaging, test results, patient demographic page, and accompanied by a corresponding order. Providers may utilize order forms specific to their clinics, or may utilize the "Physician Order Form" provided on the Project Access website.**

Please fax or e-mail to Project Access: (205) 838-6294 | alprojectaccess@uabmc.edu