eConsult Physician Request Form

Before requesting eConsult have you researched "Ask Mayo Expert" (AME) Yes ☐ No ☐

For Office Use Only:			
Date eConsult Request Received from Office:	**eHealth Coordinator:**	**Date eConsult Submitted to Mayo:**	**Date Received from Mayo:**
Requesting Physician Name and Specialty:		Patient Name (Last, First, Middle Initial):	
Office Address:		Patient Address:	
Email for Notification of Completed Referral:		Patient D.O.B. (MM/DD/YYYY):	
Office Phone:	Office Contact Person:	Patient Phone Number:	
Office Fax:	Physician Cell Contact Number:	Gender:	Date Submitted to eHealth Coordinator:

1. Diagnosis:

2. Primary Reason for the Request (pick one or more of the options):

- ☐ Is this a current assessment and/or approach correct?
- ☐ What other/ongoing diagnostics should be considered?
- ☐ Should other treatment/management options be considered?
- ☐ Should the patient be seen at Mayo Clinic?
- ☐ Is the patient a candidate for a research study?
- ☐ Other, please indicate in detail summary note about your question.

3. Reason for eConsult Request (Include *specific question* by referring care provider):

4. Requested Mayo Clinic Department:

Patient documentation relevant to the specific clinical question asked in #3 above.: (Limit total document pages to 25)

5. Patient Documentation(Within past year): Note: Label uploaded documents and images as: first name_ last name_ date of birth (MM/DD/YYYY)_ date of service_ Doc type	Included	*For Office Use Only:* Received / Verified
A. Provided by Physician's Office:	☐	☐
a. Summary Note (Additional details regarding specific question)	☐	☐
b. Office Visit Note(s) (Most recent)	☐	☐
c. Patient Medical History, Current Medications, Family History, Date of Onset (If NOT included in A or B)	☐	☐
d. If Hospitalized within Past Year, most recent Discharge Summary	☐	☐

e. Operative/Procedure Report(s)	☐	☐
f. Lab Result(s)	☐	☐
g. Radiology Study Result(s) and Dicom Image(s)	☐	☐
h. Cardiac Study Result(s) and Dicom Image(s)	☐	☐
i. Other Diagnostic Study Result(s) and Dicom Image(s)	☐	☐
A. Additional Records to be Sent: - ***List Study Name and Date of Service(s):***		
a. Imaging (e.g. CT/MRI):	☐	☐
b. Cardiac (e.g. Stress Test, EKG, Cath Study):	☐	☐
c. Operative / Procedure Reports:	☐	☐
d. Other Studies:	☐	☐
B. Pathology a. Sample Source (e.g . lymph nodes, prostate): b. Surgical / Collection Date: c. Number of Slides: d. Lab Pathology Performed: Note: If specimens are not available on-site, contact [XXXXX] to review procedure to obtain Pathology specimens		
6. Additional Details Note Included Above or in Documentation:		

When form is completed; FAX to **405-553-5668 ATTN: eHealth**
then e-mail **Nate.Draper@integrisok.com** *that the eConsult request has been submitted.*