UNIVERSITY of VIRGINIA HEALTH SYSTEM

OFFICE of TELEMEDICINE
P.O. Box 800707 • Charlottesville, VA 22908-0707
Tel: 434-924-5470 • Fax: 434-244-7521

Place Label Here

REQUEST FOR TELEMEDICINE CONSULTATION – Fax to (434) 244-7521

Requesting Organization: _____ Date: _____

New patients, please complete patient registration form and submit with this request.
Returning patients, please provide name and UVA Medical Record Number.

Patient Name: _____

UVA MRN : _____ **DOB:** _____

DOC Number : _____ **SSN:** _____

Marital Status : _____ **Race:** _____

Insurance:

Referring Physician: _____

Person Presenting Case: _____

Specialty Requested: _____ Consultant/Doctor Requested: _____

Problem Description: _____

Information available for consultation (include view & date):

X-Rays (CT, MRI, Sonogram, etc.): _____

Echo, Ultrasound: _____

Lab Work: _____

Other: _____

	Completed	To Be Completed
Provided the Patient and Family Education Handout	☐	☐
Patient Registration Information Form	☐	☐
Consent To Participate In Telemedicine Form	☐	☐
HIPAA Form	☐	☐
LTS Green Card	☐	☐

Please schedule consult for:

☐ Initial Appointment

☐ Follow-Up Appointment
(Send updated demographics & insurance)

Consult Date/Time Requested:

Request completed by: Name _____ Date _____ Time _____

For University of Virginia Office of Telemedicine Use Only

UVA Consultant: _____

Date Notified: _____

Time: _____

Scheduled Consult

Date: _____

Time: _____

Notes:

Rev. 5/20/98, 8/3/99, 7/22/03, 4/2010, 10/2010, 02/10/15, 06/22/15