UVAHealth

Karen S. Rheuban Center for Telehealth
P.O. Box 800707 • Charlottesville, VA 22908-0707
Tel: 434-924-5470 • Fax: 434-244-7521

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

Requesting Organization: ______________________ **Date:** ____________

New Patient: Please complete in full
Returning Patient: Please include Name, Email, DOB, and UVA Medical Record Number

Patient Name: ______________________ Date of Birth: ____________

Patient Email: ______________ UVA MRN: ____________ SSN: ____________

Primary Insurance: ______________________

Secondary Insurance: ______________________

Referring Physician: ______________ Specialty Requested: ______________

Person Presenting Case: ______________ Provider(s) Requested: ______________

Problem Description: ______________________

Information provided for consultation (include view & date)

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

Echo, Ultrasound: ______________________

Lab Work / Other: ______________________

Documentation Required With Request for Consult	New Patient Requests	Initial Appointment Requests	Follow-up Appointment Requests	Included/ Completed	Done/To Be Completed
Patient Demographics / Registration Information Form	Yes	Yes	Yes	☐	☐
Driver's License / State Identification Card	Yes			☐	☐
Health Insurance Card (copy of front and back)	Yes	Yes	Yes	☐	☐
Patient History/Notes, Med List, Labs	Yes	Yes	Yes	☐	☐
Telemedicine Consent Form	Yes			☐	☐
HIPAA Form	Yes			☐	☐
LTS Green Card (mail originals to UVA Telemedicine)	Yes			☐	☐
Patient and Family Education Handout	No copy needed, handout for patient / family			☐	☐

Request Completed By	**Appointment Type**	**Requested Consult Date & Time**
Name: ____________ Date: ________ Time: ________	☐ Initial ☐ Follow-Up	

Rev. 5/20/98, 8/3/99, 7/22/03, 4/2010, 10/2010, 02/10/15, 06/22/15, 05/25/17, 08/04/19