### 

### Department of Emergency Medicine

***Staff Physician Referral Questionnaire***

|  |  |  |  |
| --- | --- | --- | --- |
| ***Name:*** |  | ***Specialty:*** |  |

***1. If patient is admitted to BH through the E.D., how do you wish to be listed?***

a. Attending physician (patient admitted in your name) \_\_\_\_\_

b. Referring physician (patient admitted in Attending's name) \_\_\_\_\_

***2. About what category of patient do you wish to receive a call?***

a.all patients that come to the E.D. for treatment \_\_\_\_\_\_

b. only if the patient requires admission to the hospital, or if the patient needs immediate follow-up care in your office \_\_\_\_\_\_

c. call the Attending/Consultant on record or have the patient call my office for follow up \_\_\_\_\_

***3. If we are unable to reach you, or you have designated 2c above, who would you like called for the following specialties?***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Cardiology*** | |  | | | |
| ***ENT*** |  | | | | |
| ***Gastroenterology*** | | |  | | |
| ***General Surgery*** | | |  | | |
| ***Internal Medicine*** | | |  | | |
| Nephrology | |  | | | |
| ***Neurology*** | |  | | | |
| ***Neurosurgery*** | |  | | | |
| ***Obstetrics/Gynecology*** | | | |  | |
| ***Orthopedics*** | |  | | | |
| ***Pediatrics*** | |  | | | |
| ***Podiatry*** | |  | | | |
| ***Plastics*** | |  | | | |
| ***Pulmonology*** | |  | | | |
| ***Urology*** | |  | | | |
| ***Vascular/Thoracic Surgery*** | | | | |  |



***4. In order to contact you in an expedient manner, please provide the following:***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Office Phone# |  |  | Home # |  |  | Ans Svc # |  |
|  | | | | | | | |
| Cell Phone# |  |  | Pager # |  |  | Other # |  |

1. ***After office hours, how do you want to be contacted?***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Primary # Secondary #

1. ***For communication regarding consults, how would you like to be contacted?***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Primary # Secondary #

1. ***Please list your associates’ names:***
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

This information will help to expedite quality care for your patients and assure follow up and desired referrals – when appropriate.

Please be assured that this information will be held in professional confidence and be available only to those individuals within the Department of Emergency Medicine who require this information to make patient care decisions.

## Return Questionnaire to: Beaumont, Farmington Hills - Attention: Tamara Musch

**Medical Administration, 28050 Grand River Ave., Farmington Hills, MI 48336-5933**

**Phone: (248) 471-8222 Fax: (248) 471-8837**