Mayo Clinic eConsult Order

Fields in **bold** required.*

Requesting Physician Information

Requesting Physician Name*	**Physician Work Email Address***
Physician Direct Phone (for Mayo consultant) *	Office Contact Name / Email or Phone

Patient Information

Patient Full LEGAL Name (Last, First, Middle)*		**Sex***	**Date of Birth** (mm/dd/yyyy)*
VHC MRN	ZIP Code	Phone	

eConsult Information

Mayo Clinic Specialty Requested*	Subspecialty or Specific Consultant Requested
Specific Clinical Question*	
Associated Diagnosis (es)*	

Reason for eConsult?

- ☐ Is the current assessment and/or approach correct?
- ☐ What other/ongoing diagnostics should be considered?
- ☐ Should other treatment/management options be considered?
- ☐ Is the patient a candidate for a research study?
- ☐ Should the patient be seen at Mayo Clinic?
- ☐ Other (please note in additional details)

☐ **Yes** ☐ **No** **Is slide review indicated?** * If yes, please note specific accession(s): _____

☐ **Yes** ☐ **No** **Are images to be sent?** * If yes, please note specific studies: _____

☐ **Yes** ☐ **No** **Are all relevant records available in Epic?** * If no, please specify outside materials below.

Additional Details. (Please note any additional information or instructions regarding the request or materials to be sent below.)