Physician eConsult Request

VIRGINIA HOSPITAL CENTER

MAYO CLINIC CareNetwork Member

Patient Information

Patient Full LEGAL Name (Last, First, Middle)	Date of Birth (mm/dd/yyyy)
If shaded demographic information is included in attached clinical documents, skip to next section.	
Home Address (number, street, apt, city, state and ZIP)	Sex ☐ Male ☐ Female
Maiden Name or Other Names Used	Phone Number
Parent or Guardian Information, if patient < 18 years of age (Name, relationship, address and phone)	

eConsult Information

Diagnosis:

Primary 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?
- ☐ Should the patient be seen at Mayo Clinic?
- ☐ Is the patient a candidate for a research study?
- ☐ Other, please indicate in Details About Question

Specific Clinical Question:

Additional Details:

Relevant Clinical Information:

Attach a clinical summary and relevant records/information for the Mayo Clinic specialist to answer your specific clinical question. Referring physician is responsible for identifying the relevant information to be included and for ensuring that identified materials from outside of Virginia Hospital Center are provided to the eConsult coordinator.

Attachments:

- ☐ Clinical Summary (required)
- ☐ Clinic / Visit Notes
- ☐ Relevant Reports
- ☐ Images*
- ☐ Pathology**
- ☐ Other

* Specify study, date and facility for imaging (i.e. CT abdomen 1/13/15, VHC). If imaging performed outside of Virginia Hospital Center, obtain CD or electronic media with high-resolution images and contact eConsult coordinator for instructions.

** Specify sample source, date of surgical collection, and lab for pathology specimens. (i.e. prostate, 1/13/15, VHC). For specimens outside of Virginia Hospital Center, contact eConsult coordinator for instructions.

Physician Information / Certification

I certify that I am the requesting physician or submitting this eConsult at the request and under supervision of the requesting physician, and that the patient has consented to sharing information with Mayo Clinic for this eConsult. Requesting physician must be member of the Virginia Hospital Center Medical Staff.

Requesting Physician Name	VHC ID#	Physician Direct Phone
Office Contact Name		Office Contact Phone

PLEASE SUBMIT COMPLETE FORM AND SUPPORTING DOCUMENTS VIA SECURE FILE UPLOAD OR FAX TO 703.558.6296.

Virginia Hospital Center eConsult Office ■ Phone 703.558.6448 ■ Fax 703.558.6296 ■ econsult@virginiahospitalcenter.com