REQUEST FOR CONSULTATION

Patient name: ______________________ Age: ______ DOB: ______________

To: Dr. ______________________ From: Dr. ______________________

Ph. #: __________ Fax #: __________ Ph. #: __________ Fax #: __________

Referring Diagnosis: ____

____

Reason for Consultation:

- ❑ Consult for opinion only
- ❑ Consult and recommend treatment
- ❑ Consult and treat specific problem ______________________
- ❑ Consult and assume total care of patient

Patient history: ____

____

Significant family history: ____

____

Current meds: ____

____

Tests performed: ____

Urgency of Consult:

- ❑ Urgent, consultation needed immediately
- ❑ Please see patient within ________ hours
- ❑ Not urgent, may see within ________ days

Other requests:

- ❑ Please call with results
- ❑ Please send written consult report

Method of Request:

- ❑ In person
- ❑ Phone to doctor
- ❑ Message with office / service
- ❑ Fax

❑ I have noted the referral and the reason for the referral in my plan of care.

Signature: ______________________ Date: __________ Time: __________