

REQUEST FOR CONSULTATION

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Oncology/Hematology | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Lung Center | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Urology |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Vascular |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> _____ |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Ob/Gyn | <input type="checkbox"/> Radiology (MRI, CT, U/S) | |

REFERRING PHYSICIAN: _____ **PHONE#:** _____ **FAX #:** _____

PHYSICIAN SIGNATURE: _____

Patient Name: _____ Best Contact Phone #: _____

Address: _____ Best Time to Call: _____

Age & DOB: _____

Gender: _____

Insurance(s): _____

Policy #: _____

DIAGNOSIS AND ICD-10:

Clinic Note attached: [] Date: _____
Diagnostics: [] Completed [] Requested

DOI/Onset Date: _____
X-Rays: [] Completed [] Not Done
View(s) Taken: _____

FOLLOW UP/ For Referral Department Use Only

Date	Time	Action

APPOINTMENT

DATE: _____ **TIME:** _____ **PHYSICIAN:** _____ **MADE BY:** _____