

# Request for consultation

To Dr. \_\_\_\_\_ From Dr. \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ Fax \_\_\_\_\_

Date \_\_\_\_\_

Regarding patient \_\_\_\_\_

Patient's daytime telephone number \_\_\_\_\_

Hospital and room number (if applicable) \_\_\_\_\_

Reason for consultation \_\_\_\_\_

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

Pertinent history \_\_\_\_\_

\_\_\_\_\_

## Specific requests

- |  |   |
|--|---|
| <input type="checkbox"/> Second opinion          | <input type="checkbox"/> Evaluate & recommend           |
| <input type="checkbox"/> Order appropriate tests | <input type="checkbox"/> Perform appropriate procedures |
| <input type="checkbox"/> Follow up as indicated  | <input type="checkbox"/> Accept patient in transfer     |
| <input type="checkbox"/> Other _____             |   |

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

Please notify me promptly of your recommendation.

\_\_\_\_\_  
Signature (requesting physician)

## Insurance information

Third-party coverage \_\_\_\_\_

Referral number (if needed) \_\_\_\_\_

Consultant notified \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Signature (notifying person)