

CONSULTATION REQUEST

Patient Name:

DOB:

Address:

Phone:

Please evaluate this patient for the following problem or condition:

Symptoms:

Length of time of problem:

Family history or other pertinent issues:

Please evaluate and consider treatment as appropriate. I look forward to receiving your opinions and advice and will resume general care following your consultation.

Signed _____ M.D. Date: _____

This form may be faxed in advance of the patient's scheduled appointment or given to the patient to bring with to the appointment.

**THIS FORM DOES NOT CONSTITUTE A REFERRAL FOR INSURANCE PURPOSES.
FOLLOW YOUR INSURANCE REFERRAL GUIDELINES FOR PAYMENT FOR SPECIALISTS.**