

CONSULTATION/REFERRAL REQUEST FORM

To: Consultant

From: Primary physician

Name: _____

Name: _____

Address: _____

Address: _____

Phone/fax: _____

Phone/fax: _____

SECTION 1 – REQUESTED ACTION

Consultation

(Please send the patient back for follow-up and treatment.)

- Confirm diagnosis.
- Advise as to diagnosis.
- Suggest medication or treatment.

Referral

(Please provide primary physician with summaries of subsequent visits.)

- Assume management for this particular problem and return patient after conclusion of care.
- Assume future management of patient within your area of expertise.

SECTION 2 – PATIENT INFORMATION

Name: _____

Address: _____

Phone: _____ Date of birth: _____

Tentative diagnosis: _____

Pertinent history, physical and laboratory findings, and special financial considerations:

- See additional information attached.
- Please call me when you have seen the patient.
- I would like to receive periodic status reports on this patient.
- Please send a thorough written report when the consultation is complete.

Signature: _____

PRIMARY PHYSICIAN

SECTION 3 – CONSULTANT'S FINDINGS

- I would like to receive periodic status reports on this patient.

Signature: _____

CONSULTANT

Primary physician: Complete sections 1 and 2. Send one copy to the consultant and keep one copy in the patient's chart or in a tickler file.

Consultant: Complete section 3. Return one copy to the primary physician after your initial visit with the patient. Keep one copy for your records.

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