CONSULTATION/REFERRAL REQUEST FORM

To: Consultant

Name: _____

Address: _____

Phone/fax: _____

From: Primary physician

Name: _____

Address: _____

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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