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.