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REQUEST FOR CONSULTATION

REFERRING PHYSICIAN INFORMATION

Date: _____
 Referring Physician's Name: _____
 Address: _____ Fax Number: _____
 Contact Name: _____ Phone Number: _____

MEDICAL INFORMATION NEEDED

Gender: M F
 Name: First: _____ Middle: _____ Last: _____
 DOB: _____ SS#: _____
 Address: _____
 Phone #: _____ Cell #: _____ Work #: _____

Please send insurance cards:

Primary: _____ Secondary: _____
 Member ID: _____ Member ID: _____
 If HMO, Authorization #: _____ ***Please attach authorization***

REQUESTED APPOINTMENT

Reason for Referral, Symptoms and Diagnosis: *(please be specific and state area of involvement)* _____

REQUESTED APPOINTMENT

***Please send the following records:**

_____ Office Notes	_____ Pathology	Prostate: _____ PSA	Breast: _____ Mammo
_____ Operative Notes	_____ PET/CT	Ovarian: _____ CA-125	_____ Ultrasound
_____ Labs	_____ Radiation Past	Colon: _____ CEA	_____ MRI
_____ Scans	_____ Radiation Current	_____ Colonoscopy	_____ ER/PR
		Pancreatic: _____ CA 19-9	_____ HER 2 NEU by FISH
			_____ HER 2 NEU