

CONSULTATION REPORT

Family Name	First Name	Attending Physician	Room No.	Hosp. No.
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TO: (Consultant and/or Service)

REQUEST: Reason for Requested Consultation

Request Date	
Time	a.m. p.m.

CONSULTANT: Findings and Recommendations (Consultant's signature must appear at end of the report.)

Consultation Date	
Time	a.m. p.m.

CONSULTATION REPORT (CONTINUED)

