Hospital Center

CONSULTATION REQUEST AND REPORT

TO BE COMPLETED BY REFERRING PHYSICIAN (PLEASE OBTAIN BASIC LAB WORK AND X-RAYS)

REFERRING M.D.	DEPARTMENT
CONSULTANT	DEPARTMENT

REASON FOR CONSULTATION

ALSO REQUESTED OF CONSULTANT	Give Clinical Opinion ☐	Follow Up Care As Necessary ☐	Write Orders ☐ Arrange Tests ☐	Other (Please Specify) ☐

DATE	SIGNATURE OF REFERRING M.D.

CONSULTATION

1. MEDICAL RECORD 2. REFERRING PHYSICIAN 3. CONSULTANT

Signature of Consultant