

New Patient Referral/Consultation Information

Visit Date: _____ Name: _____
Specialist: _____ Address: _____
Specialty: _____ Birthdate/Age: _____ Sex: _____
Referring Physician: _____ Unit Number: _____

Print clearly in ink or stamp with patient card.

Primary Care Provider

Please complete top part and FAX to _____ at: _____ TODAY. Thank you!
Please ignore if you have already completed.

Reason for Referral:

Brief History *Including any work-up that has been done thus far*

Special Concerns, if Any: _____ Please Contact Me to Discuss

Current Meds: _____

Other Pertinent Information *Specialists seen, growth charts, lab results, etc. Please include pertinent copies with this FAX, if possible.:*

Specialist

Please complete and FAX to _____ at: _____ TODAY. Thank you!

Initial Diagnosis/Thoughts Behind It: *If applicable*

Pertinent PE and Lab Findings So Far:

Initial Plan:

I will: Obtain Labs/Other Procedures
Prescribe Medications
Perform Follow-up

Requests for PCP to:

Obtain Studies: *Specify*

_____ See Patient for Follow-up Regarding:

_____ Please Contact Me to Discuss:

_____ Other:

Full report to follow.