

## NEW PATIENT REFERRAL/CONSULTATION INFORMATION

## 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		TODAY TILL
Please complete top part and FAX to INSERT: Phy Please ignore if you have already completed.	sician's Name at: Fax numbe	er TODAY. Thank you!
Reason for Referral:		
Brief History Including any work-up that has been do	ne thus far	
Special Concerns, if Any:		☐ Please Contact Me to Discuss
Current Meds:		
Other Pertinent Information Specialists seen, growth	charts, lab results, etc. Please includ	e pertinent copies with this FAX, if possible.:
<u>Specialist</u>		
Please complete and FAX to INSERT: Physician's N	Name at: Fax numbe	r TODAY. Thank you!
Initial Diagnosis/Thoughts Behind I	t: 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:		

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