Consultation Verification Form

☐ FAX ☐ TELEPHONE* ☐ WRITTEN REQUEST

REQUESTING PHYSICIAN	CONSULTING PHYSICIAN
PRACTICE NAME	PRACTICE NAME
STAFF CONTACT	STAFF CONTACT
PHONE NUMBER	PHONE NUMBER
FAX NUMBER	FAX NUMBER
NUMBER OF PAGES	DATE REQUESTED

Urgent: Please have physician review. This is a verification for request of a consultation. If this request for consultation is not valid, please contact our office immediately. Make sure this request for consultation and the reason for the request is documented in the patient's medical chart.

Please have your physician:

Check the appropriate request for services on: ______________________
PATIENT NAME

Fill in patient diagnosis/condition/sign & symptom

Sign at bottom to verify consultation request

Request for Consultation/Opinion on:______________________
PATIENT DIAGNOSIS/CONDITION/SIGNS & SYMPTOMS

☐ Opinion or advice sought on patient diagnosis/condition/treatment

☐ Diagnostic or therapeutic treatment may be initiated subsequent to opinion

Request Dr. ____________ **assume care of:** ______________________
PATIENT DIAGNOSIS/CONDITION/SIGNS & SYMPTOMS

☐ Transfer of care for management of patient

☐ May be either total patient care or transfer of care for specified diagnosis/condition/sign & symptoms

☐ Transfer of care must be approved by rendering physician prior to visit

SIGNATURE OF REQUESTING PHYSICIAN OR OFFICE STAFF DATE VERIFIED

* If verified by telephone, record date and staff person who verified consultation request.

Message: If you do not receive all the pages indicated on the above line, please call us immediately so that we may re-send the missing sheets. Thank you.

CONFIDENTIALITY NOTICE

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