

CONSULTATION REQUEST

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DATE _____

REFERRING DOCTOR _____

CLINIC _____

ADDRESS _____

TELEPHONE (include area code) _____

PATIENT'S NAME _____

M F DATE OF BIRTH _____ OCCUPATION _____

HISTORY OF: TRAUMA NO YES SURGERY NO YES MALIGNANCY NO YES

IF YES, DATE OF AND DESCRIBE BELOW

SIGNIFICANT SYMPTOMS AND CLINICAL FINDINGS

X-RAYS/SCANS SUBMITTED FOR INTERPRETATION

VIEWS/STUDY _____ DATED _____

VIEWS/STUDY _____ DATED _____

VIEWS/STUDY _____ DATED _____

- TELEPHONE CONSULTATION
- WRITTEN REPORT
- TELEPHONE CONSULTATION AND WRITTEN REPORT

FAX REPORT FAX # _____

GENERAL REPORT

SPECIAL CONCERN OR QUESTIONABLE FINDING (DESCRIBE BELOW)

COMMENTS: _____
