CONSULTATION REQUEST

DR VINTON L. ALBERS • PO BOX 240129 • APPLE VALLEY MN 55124-0129
• E-mail: drvalbers@gmail.com • www.drvalbers.com
952-432-3320 • Fax: 952-432-3320

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: _____

_____