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

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SIGNIFICANT SYMPTOMS AND CLINICAL FINDINGS

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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: ____

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