CONSULTATION REQUEST------REVIEW

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DATE _____

REFERRING DOCTOR/CLINIC _____

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 _____

☐ REVIEW ONLY
☐ TELEPHONE CONSULTATION PHONE # _____
☐ WRITTEN REPORT
☐ FAX_____

☐ QUESTIONABLE FINDING OR SPECIAL CONCERN (DESCRIBE BELOW)

COMMENTS: _____

_____

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