CONSULTATION REQUEST

Dr. Vinton L. Albers
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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:

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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 _____________________

☐ REVIEW ONLY
☐ TELEPHONE CONSULTATION PHONE # ____________________________
☐ WRITTEN REPORT

☐ QUESTIONABLE FINDING OR SPECIAL CONCERN (DESCRIBE BELOW)

COMMENTS: ____

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