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**CONSULTATION REQUEST----REVIEW**

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

QUESTIONABLE FINDING OR SPECIAL CONCERN (DESCRIBE BELOW)

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_