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Request for Consultation

Internal Medicine/Geriatrics ☐ Gynecology ☐ Cardiology ☐ Gastroenterology ☐

Please fill in all information and fax to our office. Patients will be contacted directly. Fax: 1-888-501-9616

PATIENT INFORMATION (PATIENT LABEL)

Name: _____

DOB: _____ Gender: ☐ F ☐ M

Height: _____ Weight: _____

Address: _____

_____

Phone #: _____

HIN: _____

REFERRING PHYSICIAN'S INFORMATION

Name: _____

Phone #: _____

Fax #: _____

Address: _____

_____

Billing #: _____

Signature: _____

REASON FOR REFERRAL _____

_____

_____

_____

MEDICAL HISTORY

☐ MI / CAD	☐ Asthma	☐ COPD	☐ Skin Problems	☐ Panic Attacks	☐ Arthritis
☐ Hypertension	☐ CHF	☐ Traumatic Brain Injury	☐ Lyme Disease	☐ PTSD	☐ Migraines
☐ MVA Accident	☐ Cancer	☐ Fibromyalgia	☐ Seizures	☐ OCD	☐ IBS
☐ Diabetes	☐ Alcoholism	☐ Chronic Pain	☐ Bruxism	☐ Mood Disorder	☐ GERD

Other: _____

Current Medication: _____

_____

Allergies: ☐ NKA ☐ NKDA _____

OTHER RELEVANT MEDICAL HISTORY _____

_____

_____

OFFICE USE ONLY: Date Received: _____ Appointment Date: _____