MEDICAL CONSULTATION REQUEST FORM

To: Dr. _____

_____

_____

Re: _____

Patient Name

_____

Date of Birth

Please complete the form below and return it to

Dr. _____

_____

_____

Phone # _____

Fax # _____

Our mutual patient has presented to my office, with the following problem(s): _____

_____

I have recommended the following treatment/procedure: _____

_____

_____,

and _____ anesthesia **will** be used.

The procedure will be performed in a(n): ☐Office ☐Hospital

After reviewing this patient's health history, my concerns include: _____

_____

_____

PHYSICIAN'S RESPONSE

Please indicate any treatment recommendations below

Are there any medical contraindication(s) to the proposed treatment/procedure and/or modifications that should be made to the patient's current prescribed medication regimen? ☐Yes ☐No

If yes, what are they? _____

_____

_____

Additional precautions: _____

_____

Lab results (if applicable): _____

_____

Physician Signature

_____

Date

PATIENT CONSENT(optional) *I agree to the release of my medical information to the office named above*

_____

Patient Signature

_____

Date