

General Surgery Consult Request

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(740) 615.0450

PLEASE COMPLETE FORM AND FAX TO (740) 615.0462

1 Referring Physician: _____ Date: _____
Office Contact Name: _____

2 Patient Information

Name: _____

Address: _____

Phone: _____

D.O.B. : _____

Soc. Sec. #: _____

3 Required Information

+ Copy of Insurance Card

+ Copy of ALL Medications/Allergies

+ Blood Thinners/ASA Therapy? Y / N

• Able to Hold 7 Days? Y / N

• Managing Physician (if other than referring):

4 Nature of Problem/Diagnosis

5 Request

Office Consult

Colonoscopy

Upper Endoscopy

Other: _____

6 Urgency

Immediately (~1-3 days)

As Soon As Possible (~3-7 days)

Elective (~1-2 weeks)

Other: _____

Once received, we will fax back receipt of request, call the patient to make all necessary arrangements, and fax confirmation of the scheduled visit back to you. If we encounter any difficulty accommodating your request, we will contact you promptly.

Thank you for entrusting us with your patient's care.

Your patient is scheduled for:

Athena

QuadraMed

OPCC/Ref Faxed

Precert Complete

Instructions Mailed

Antibiotics Required Y/N

FOR OFFICE USE ONLY:

1st _____ 2nd _____ Letter _____

Pharmacy _____



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