CONSULT/PROCEDURE REQUEST

Patient's name: _____ Date of birth: _____

Patient's phone #: _____ Alternative #: _____

I want this patient evaluated by (specify provider or specialty):

_____

- ❖ Please include a copy of patient's insurance information or insurance card
- ❖ Prior authorization must be completed by requesting practitioner prior to scheduling a consult or testing if needed

Reason for consult (Be specific):

_____

_____

_____

Signature of Provider requesting consult: _____ Date: _____

Printed name of provider requesting consult: _____

Please FAX (563-557-5560) any pertinent records (e.g. last history and physical, if available; most recent progress note that addresses problem prompting consultation), any pertinent laboratory and/or radiology information. Current medication list is required.

□ Patient notified of consult □ Notes sent to consulting physician on _____(date)

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Dubuque, IA 52001
563-557-9111 (office)
563-589-4848 (to schedule an appointment)
563-557-5560 (fax)

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