

HAYSMED

HaysMed Family Medicine
**Request for Consultation, New Patient,
or Self Referral**

2509 Canterbury Drive | Hays, KS 67601 | 785.623.5095 | FAX 785.623.5080

☐ *Consultation*

☐ *New Patient/Self Referral*

Patient Name: _____ Date: _____

DOB: _____ SSN: _____

Phone Numbers Home: _____ Cell: _____ Work: _____

Address: _____

City

State

Zip Code

Requesting Physician: _____

Physician's Address: _____

City

State

Zip Code

Phone: _____ Fax: _____

Requested Physician: _____ or ☐ **First Available**

Reason for Consultation:

Is the patient a Veteran? ☐ Yes ☐ No If yes, has a request of service (ROS) been sent? ☐ Yes ☐ No

Appointment Date: _____ Time: _____

Clinics: Please fax the following information with the completed form.

☐ Demographics

☐ Lab Reports

☐ History & Physical

☐ Imaging Reports

☐ Current and Complete Medication List

☐ Pathology Reports

Signature of Person Completing Form

Date/Time



Form # CLI 181 Revised 7/13, 11/14, 11/15, 1/17, 2/23

DOB: D A/Sdt:

