

## Request for Consultation, New Patient, or Self Referral

2220 Canterbury Drive | Hays, KS 67601 | 785.625.4699 | FAX 785.261.7424

Consultation

New Patient/Self Referral

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Phone Numbers    Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Insurance: \_\_\_\_\_

Requesting Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Requested Physician:** \_\_\_\_\_ or  **First Available**

**Reason for Consultation:**

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

Anticoagulation Therapy (ASA, Plavix, Coumadin, Pradaxa, Xarelto, Heparin, Eliquis, etc.):  Yes  No

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

Demographics/Insurance card  
 History and Physical  
 EKG

Lab Reports  
 Imaging Reports  
 Cardiac Imaging Reports

Pathology Reports  
 Current and Complete Medication List

Signature of Person Completing Form

Date/Time

