

# 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: \_\_\_\_\_

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**

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

**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

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

- Demographics
  - History & Physical
  - Current and Complete Medication List
  - Lab Reports
  - Imaging Reports
  - Pathology Reports

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### Signature of Person Completing Form

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**Date/Time**

