

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

2214 Canterbury Drive, Suite 204

Hays, KS 67601

785.623.2360

FAX: 785.623.2371

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:** \_\_\_\_\_  **First Available**

**Reason for Consultation:**

Birth Weight: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**Clinics: Please fax the most recent information with the completed form.**

<input type="checkbox"/> Demographics	<input type="checkbox"/> Imaging Reports	<input type="checkbox"/> KanBeHealthy
<input type="checkbox"/> Birth Records	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> History and Physical or Visit Notes
<input type="checkbox"/> Growth Chart	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Current and Complete Medication List

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Date/Time

