HAYSMED

Southwind Surgical

Request for Consultation, New Patient, or Self Referral

2500 Canterbury Drive, Suite 202 | Hays, KS 67601 | 785-623-5945 | FAX: 785-623-5949

❑ *Consultation* ❑ *New Patient/Self Referral*

Patient Name:_____ DOB:_____ Date:_____

SSN:_____ Phone- Home:_____ Cell:_____ Work:_____

Address:_____ City:_____ State:_____ Zip:_____

Requesting Physician:_____ Address:_____

Phone:_____ Fax:_____

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

Reason for Consultation:

- ❑ Office Visit/Consult
- ❑ Colonoscope
- ❑ EGD
- ❑ Colonoscope/EGD

❑ Other Reason:

_____

_____

Diagnosis: _____

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

Diabetic: ❑ Yes ❑ No

Anticoagulation Therapy (ASA, clopidogrel (Plavix), warfarin (Coumadin), dabigatran (Pradaxa), rivaroxaban (Xarelto), heparin, apixaban (Eliquis), etc.) **Need anti-coagulation order for holding** : ❑ Yes ❑ No

Herbal Supplements: ❑ Yes ❑ No

❑ Requested Appointment Date:_____ ❑ Southwind Surgical to schedule appointment

Clinics: Please fax the following information with completed form

- ❑ Demographics
- ❑ History and Physical
- ❑ Lab Reports (pertinent to current referral issue)
- ❑ Imaging Reports (pertinent to current referral issue)
- ❑ Pathology Reports (pertinent to current referral issue)
- ❑ Current and Complete Medication List
- ❑ Previous Op Notes/Procedure Notes, if Applicable
- ❑ Send Cloud Images to HaysMed if Applicable

_____ _____

Signature of Person Completing Form **Date/Time**

Form # CLI 185 Revised 7/13, 6/15, 12/16, 2/23, 3/25, 7/25