CONSULT/TRANSFER OF CARE REQUEST FORM

To:_______________	From:_______________
Department/Specialty:_______________	Address:_______________
Phone #:_______________	Phone #:_______________
Fax #:_______________	Fax #:_______________

Has the patient received any related services at another facility? ___Yes ___No

☐ Please provide your advice or opinion for treatment of this problem.

PROBLEM:____

☐ Please assume care of this problem.

PROBLEM:____

Appointment Requested: ___ Emergent ___ Urgent (< 3 days) ___ 4-14 days ___ Routine

Date:_______________ **Provider Signature:**_______________________________

NPI#_______________________