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Hospital Consult Request Form

Consult Request Guidelines

1. Please fax this complete form, face sheet, and clinical notes to 888-959-8367.

Physician/Nurse Request Consult

Name: ______________________ Date and Time: ______________________

NPI: ______________________ Department: ______________________

Email and Fax: ______________________ Telephone: ______________________

Patient Information

Patient Room/Floor: ______________________

Patient Name, DOB: ______________________

Parents' Name: ______________________

Patient Cell Phone: ______________________

Diagnosis and Vision Acuity: ______________________

Brief background and Reason for request ______________________

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Hospital Contact Information

Name: ______________________ Telephone ______________________

Email ______________________ Fax: ______________________

Address ______________________