Consultation Request Form

Fax completed consult request form to any of the following numbers:

717.741.0372 • 717.741.9641 • 717.741.9651 •717.741.9867

Date: ________________

Check one: ☐ Urgent 24-48 Hours (IF URGENT, PLEASE CALL PHYSICIAN PRIVATE LINE: 717.747.8320)

☐ Non-Urgent

Referring Provider (please print): ____

Referring Provider Signature Required: ____

Clinical Information:
Symptoms/Reason for Consultation: (please specify when applicable) ☐ LEFT ☐ RIGHT ☐ BILATERAL

____

ICD 10 Diagnosis Verbiage: ______________________

Special needs: ☐ Language Interpreter Needed ☐ Hearing Impaired Interpreter Needed

Specialty of Choice: ☐ Orthopaedic ☐ Podiatry ☐ Pain Mgmt/EMG ☐ Rheumatology ☐ Physical Therapy

☐ Sports Medicine ☐ Female Athlete Program

Provider Preference: ____

Physical Therapy Referrals - Please list how many times per week and the total number of weeks

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Patient Name: (print please) ____
(first) (mi) (last)

Name of parent/guardian if patient is a minor: ____

Date-of-Birth: ________ /________ /_________ Phone Number: _______________________________________
Mo Day Year

Please fax the insurance REFERRAL if required along with patient demographic/face sheet, AND also a COPY OF THE PATIENT'S INSURANCE CARD.

osshealth.com

5/28/20