Consultation Request Form

Fax completed consult request form to (717) 718-4293

Date: _____

Check one: ☐ Urgent 24-48 hours *(IF URGENT, PLEASE CALL (717) 848-4800)*
☐ Non-urgent

Referring Provider *(print)*: _____

Referring Provider Signature *(required)*: _____

Clinical Information

Symptoms/reason for consultation *(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 ☐ Physical Therapy
☐ Sports Medicine ☐ Female Athlete Clinic ☐ Bone Health Clinic

Provider preference: _____

Physical Therapy referrals *(evaluate and treat)*:

Frequency/times per week: _____ Duration/# of weeks: _____

Patient Name *(print)*: _____
first *middle initial* *last*

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

Date of birth: _____ / _____ / _____ Phone number: _____

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