



5002 Cowhorn Creek Drive
 Texarkana, Tx. 75503
 Phone: (903) 614-3002
 Fax: (903) 614-3504

PEDIATRICS

CONSULT (Request for advice / opinion) or **REFERRAL** (Request for management of care)
 (Please only select one request)

REQUESTING PROVIDER INFORMATION

Requesting Provider Name		Requesting Provider Address (street, city, state, zip)	
Requesting Provider Telephone	Requesting Provider Fax Number	NPI #	
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APPOINTMENT REQUEST

DIAGNOSIS

<input type="checkbox"/> First Available <input type="checkbox"/> R. Clark Green, MD <input type="checkbox"/> Christina Payne, MD <input type="checkbox"/> Roy L. Deskin, MD <input type="checkbox"/> Mark Wright, MD <input type="checkbox"/> Douglas Cogdill, MD <input type="checkbox"/> Cheryl Saul-Sehy, MD <input type="checkbox"/> Zach King, MD <input type="checkbox"/> Cindy Porter, MD <input type="checkbox"/> Barbara Yowell, NP			
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PATIENT and INSURANCE INFORMATION

Patient Name (First, Middle Initial, Last)	Gender
	<input type="checkbox"/> Male <input type="checkbox"/> Female

Address	City, State, Zip

Date of Birth (mm/dd/yyyy)	Social Security #
/ /	- -

Home Telephone	Mobile Telephone	Work Telephone
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Does patient need an interpreter?	If yes, what language?
<input type="checkbox"/> Y <input type="checkbox"/> N	

Does the patient have medical insurance?	Name of Insurance Company and Plan Number and Group Number
<input type="checkbox"/> Y <input type="checkbox"/> N	

DOCUMENTATION

*Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 614-3504.
 Thank you in advance for the consult request and your cooperation.*

*Collom & Carney Clinic INNER OFFICE USE ONLY
 Please scan form to Chart Note for Clinic Physician*

Patient MR#	Patient ID #
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