



5002 Cowhorn Creek Drive
Texarkana, Tx. 75503
Phone: (903) 614-3010
Fax: (903) 614-3518

PHYSIATRY

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 # | |
| () - - - | () - - - | | |

APPOINTMENT REQUEST

DIAGNOSIS

| | |
|---|--|
| <input type="checkbox"/> Richard Sharp, MD | |
|---|--|

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 |
| () - - - | () - - - | () - - xtn |

| | |
|---|------------------------|
| 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) 614-3518.

Thank you in advance for the request and your cooperation.

| | |
|--------------|--------------|
| Patient MR # | Patient ID # |
| | |