



# Referral/Consult Request

www.phcgi.com

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Requesting provider: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_ Appointment date & time: \_\_\_\_\_

Address: \_\_\_\_\_

Home ph.: \_\_\_\_\_

Cell ph.: \_\_\_\_\_

Referral

Consult and Treat as Needed

Reason for request: \_\_\_\_\_

Medical Records:

Notes faxed  Notes mailed (please include applicable labs/pathology and radiology reports)

Records sent electronically (direct messaging)

*Please include a demographic sheet for the patient along with a copy of their insurance card*

### Insurance Information

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

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