

CONSULTATION

TO (Name of Consultant/Consulting Service):	FROM (Name of Requesting Physician/Service):
---	--

Date of Request / /	Time of Request : <input type="checkbox"/> AM <input type="checkbox"/> PM
-----------------------------	---

PERFORM STAT IF CHECKED →	← PERFORM STAT IF CHECKED
----------------------------------	----------------------------------

AT THE REQUEST OF THE PHYSICIAN SIGNED BELOW, PLEASE EVALUATE THIS PATIENT (AND INITIATE TREATMENT, IF APPROPRIATE) AND PROVIDE ADVICE / OPINION TO THE REQUESTING PHYSICIAN REGARDING THE FOLLOWING CONDITION(S):

Provisional Diagnoses: _____

REQUESTING PHYSICIAN'S SIGNATURE (include credentials, i.e., M.D., D.O.)	PAGER NUMBER
---	--------------

CONSULTATION REPORT

Date of Service / /	Time of Service : <input type="checkbox"/> AM <input type="checkbox"/> PM
-----------------------------	---

Place of Service: Emergency Department* Inpatient Hospital Office* Outpatient Hospital* Other _____

*IMPORTANT: Consultations performed in locations marked with an asterisk require a separate, written report to the requesting physician.

If checked, this form **IS NOT** the final Consultation Report. Final Consultation Report was dictated on _____ (mm/dd/yyyy) at _____ AM/PM. Signature of Consulting Physician

CHIEF COMPLAINT (CC)

Reason for patient being seen today _____

Street Address, Suite Number City, State, Zip+4	CONSULTATION
Logo Placement	Page 1 of 6 Form ##### Revised Form 03/2007
	#####

Date of Service / /

CONSULTATION REPORT, continued

HISTORY OF PRESENT ILLNESS (HPI) OR STATUS OF CHRONIC OR INACTIVE CONDITIONS

History of Present Illness (HPI) (Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated signs/symptoms--1-3 brief, 4+ extended)

Multiple horizontal lines for text entry.

REVIEW OF SYSTEMS

Is the patient having any current problems, signs, or symptoms in any of the following areas?
(Provider MUST comment on all "Yes" responses.)

YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/> Constitutional	<input type="checkbox"/>	<input type="checkbox"/> Integumentary (Skin & Breast)
<input type="checkbox"/>	<input type="checkbox"/> Eyes	<input type="checkbox"/>	<input type="checkbox"/> Neurological
<input type="checkbox"/>	<input type="checkbox"/> Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/> Psychiatric
<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Endocrine
<input type="checkbox"/>	<input type="checkbox"/> Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Hematologic/Lymphatic
<input type="checkbox"/>	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/> Allergy/Immunology
<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/> Other _____

All other systems reviewed and negative

Last Menstrual Period _____ (mm/dd/yyyy)

Review of Systems: 1=Problem Pertinent, 2-9 =Extended, 10+=Complete

PROVIDER COMMENTS--REVIEW OF SYSTEMS

Multiple horizontal lines for text entry.

Street Address, Suite Number
City, State, Zip+4

Logo Placement

CONSULTATION

Page 2 of 6

Form #####

Revised Form 03/2007

#####

CONSULTATION

Date of Service / /

CONSULTATION REPORT, continued

PAST MEDICAL, FAMILY, AND SOCIAL HISTORY

Past Medical History (Allergies, Childhood Illnesses, Hospitalizations and Operations, Immunizations, Medications, Transfusions, Traumas) _____

Family History (Document diseases related to the Chief Complaint(s), History of Present Illnesses, or Review of Systems, Hereditary or High Risk Diseases for the patient's parents, siblings and/or children) _____

Social History (Alcohol Use, Educational History, Employment History, High Risk Behavior, Illicit Drug Use, Living Arrangements, Marital Status, Sexual Activity/Contraceptive Use, Tobacco Use, Travel History)

TIME SPENT COUNSELING AND/OR COORDINATING CARE

When this box is checked, more than fifty percent (50%) of this service was teaching physician time spent counseling the patient and/or coordinating patient care. DO NOT count any resident time, medical student time, nonphysician practitioner (NPP) time or other staff time spent counseling this patient and/or coordinating patient care.

Total Time of Visit _____ Time Spent in Counseling _____

Details of counseling and/or coordination of care MUST be documented!

Street Address, Suite Number
City, State, Zip+4

Logo

CONSULTATION

Page 3 of 6

Form #####

Revised Form 03/2007

#####

Placement

#####

CONSULTATION

Page 4 of 6

Date of Service / /

CONSULTATION REPORT, continued

PHYSICAL EXAMINATION

Lined area for physical examination notes.

Street Address, Suite Number
City, State, Zip+4

CONSULTATION

Page 4 of 6

Form #####

Revised Form 03/2007

**Logo
Placement**

#####

