

## Request for Consult or Procedure

Today's Date: \_\_\_\_\_

**Referring to (check one):**

- Dr. Paul Johnson, MD       Dr. Jessica Brown, MD       First Available, No Preference  
 Dr. Luke E. Johnson, MD       Kaylee Wiens, PA

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signs/Symptoms/Diagnosis: \_\_\_\_\_

Office Visit       Procedure \_\_\_\_\_

Location:  Salina       Rooks County       Ellsworth       Any Location, No Preference

Referring Provider: \_\_\_\_\_

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

**DOCUMENTATION NEEDED:**

(Lack of records will delay the referral process)

- Demographics Sheet
- Copy of Insurance Card(s)
- Records Related to Referral (Office Notes, Imaging, Lab, Procedures, Etc)

*We will call the patient to schedule an appointment and notify you of the date and time via fax.*

*FOR RECEIVING OFFICE ONLY IN RESPONSE TO REFERRAL REQUEST*

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Please arrive \_\_\_\_\_ minutes prior.

Location: \_\_\_\_\_

Provider: \_\_\_\_\_

Additional Information: \_\_\_\_\_