

**CONSULTATION REQUEST**

IN ORDER TO PROVIDE A TIMELY RESPONSE TO A REQUESTING PHYSICIAN OR PRACTITIONER, PLEASE FILL OUT THE FOLLOWING

The following is a request for a consultation. The request may be requested with this form, a written prescription, telephone call, formal letter or an informal letter/note as long as it is signed. There must be a reason for the consult and a contact address where a separate consultation response report may be sent.

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PATIENT SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

The reason for the consultation must be included. Date of Request: \_\_\_\_\_

**REQUEST FOR CONSULTATION:**

I \_\_\_\_\_, hereby request a consultation for the aforementioned patient  
(Printed name of requesting physician)

in reference to the following concerns (diagnosis or symptoms); \_\_\_\_\_

Sincerely,

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

(Title) \_\_\_\_\_ Phone: \_\_\_\_\_

A formal consultation report will be furnished to the requesting physician or qualified non-physician practitioner requesting this consultation.

MAIL TO: R. LEVINE, MD 1157 South Adams Road, Birmingham Michigan 48009  
PHONE CALLS TO: ROBERT C. LEVINE, MD (248) 646-8600  
FAX TO: (248) 646-4073