PRACTICE NAME
Practice Street Address
Suite X
Practice City, State Zip
Practice Phone Number

REQUEST FOR OPINION

Consultation request from: Doctor "A" ϕ
Doctor "B" γ
Doctor "C" ϕ

To: Consultant's Name:_____
Specialty:_____

Re: Patient Name:_____
Date:_____

Please provide an opinion and consult for the above named patient. This patient is being sent to you for the following reasons:

_____

_____

_____

_____

_____

_____

_____

We understand that you may initiate treatment or perform medicallly necessary diagnostics for this patient. We look forward to your opinion and plan of care:

_____
Practice Name
"A", MD
"B", DO
"C", MD