Print Form

DERMATOLOGY OF CENTRAL OHIO

DR. J. MICHAEL HOLSINGER, DO
VERA SMITH, PA-C

CONSULTATION REQUEST FORM

Date of request:

Name of consult-seeking provider: _____

Address: _____

Phone: Fax:

Reference consult request for patient: _____
(Name of patient for whom a consult has been requested)

Patient's Address: _____ Phone#:

_____ Date of Birth:

Patient's Insurance: _____

Diagnosis (if one was made): _____

Treatment rendered (if any): _____

_____

_____

_____
Signature of consult-seeking physician

PLEASE SCHEDULE PATIENT WITH **PHYSICIAN** _____

PLEASE SCHEDULE PATIENT WITH **PHYSICIAN ASSITANT** _____

PLEASE SCHEDULE PATIENT WITH **ANY PROVIDER** _____

Please fax consultation request to (614) 866-8699. Upon receipt of this consultation request, an employee from Dermatology of Central Ohio will contact your patient to schedule their appointment.