LANGLEY PORTER PSYCHIATRIC HOSPITAL & CLINICS

Consultation Request Form

Thank you for choosing to refer your patient to us for consultation. To start the referral process, please fax this form with any brief, relevant medical records to 502-6361.
For referrals for ongoing care, patients may call 476-7500 to schedule an appointment.

From: _____ Date: _____

Title: _____ # of Pages: _____

Phone: _____ Fax: _____

Patient Information:

Name of patient: _____ DOB: _____

If child, name of parent/legal guardian: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Address: _____

City: _____ Zip: _____

Insurance: _____

Consultation request information:

Name of Referring MD: _____ Specialty: _____

Phone: _____ Fax: _____

Address to which consultation report should be sent:

Address: _____

City: _____ Zip: _____

Reason for consultation: _____

_____

_____

_____

Diagnosis: _____