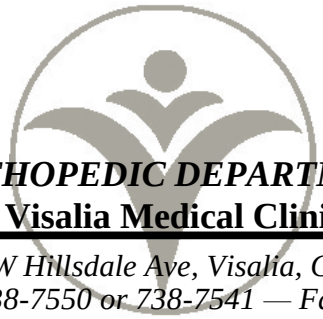

ORTHOPEDIC DEPARTMENT

Visalia Medical Clinic

5400 W Hillsdale Ave, Visalia, Ca. 93291
Phone: 559/738-7550 or 738-7541 — Fax: 559/738-7586

PATIENT CONSULTATION REQUEST FORM

Patient Information

Name:_____

DOB:_____ Telephone: _____ Cell:_____

Insurance: _____

Authorization# (if needed): _____

Date of Request: _____

Requested by: **Dr.** _____ Address: _____

Phone Number: _____ Fax: _____

This appointment is being requested for my patient for the following reason:

☐ Consultation & treatment if needed with:

- ◯ Dr. Jason Mihalcin D.O.
- ◯ Dr. James Guadagni M.D.
- ◯
- ◯ OR next available appointment

☐ Transfer of care

Reason for consultation *(please be specific):* _____

_____

Please have patient bring a list of current medications.

Signature of Requesting Physician: _____

***Note:* Please fax this completed form, copy of insurance card, pertinent progress notes, labs and x-rays to our office as quickly as possible. Failure to return the completed form and records may result in delay in scheduling the patient's appointment**

Please file completed form in patient's chart

$50.00 FEE FOR FAILED APPOINTMENTS