



**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. James Guadagni

Dr. Jeff Rubio P.A.

Dr. Jason Mihalcin D.O.

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**