OUTPATIENT CONSULT

FORM TO BE SENT WITH RESIDENT

RESIDENT: _____ ROOM/BED#: _____ DOB: _____

PRIMARY CARE PHYSICIAN: _____

DIAGNOSIS: _____

_____

CONSULTING PHYSICIAN: _____ APPT. DATE/TIME: _____

PRIOR AUTHORIZATION OBTAINED? YES ☐ NO ☐ BY WHOM? _____
RESPONSIBLE PARTY NOTIFIED? YES ☐ NO ☐ BY WHOM? _____

REASON FOR CONSULT: _____

_____

NURSING COMMENT: _____

_____

CONSULTING PHYSICIAN PROGRESS NOTES: _____

_____

_____

NEW ORDERS/MEDICATIONS/TREATMENTS: _____

_____

_____

*****NEW DIAGNOSIS TO GO WITH NEW MEDICATIONS: _____

_____

CONSULTING PHYSICIAN SIGNATURE: _____ DATE: _____

PRIMARY CARE PHYSICIAN SIGNATURE: _____ YES ☐ NO ☐
(AGREE WITH ORDERS/DIAG/MED)

THIS FORM MUST BE RETURNED, WITH RESIDENT, TO HAVASU NURSING CENTER