OSF HEALTHCARE
Cardiovascular Institute

Pt Account #_ _____

CONSULTATION REQUEST

Date:_ _____
Time:_____
Initials:_____

Patient's Name: _____

M/F DOB:_____

Patient Address:_____

Home Phone: _____ Work Phone: _____ Best to call: AM/PM

Name of Insurance Carrier:_____

Referring Physician:_____ Phone #:_____

Fax #_____

Contact Person:_____ Primary Physician:_ _____

Consult Information:
Reason for Consult: _____

_____

If a physician is requested: _____

Does patient have a device? _____ Any previous cardiac surgery? _____ Any previous cardiac history? ____

Pertinent medical records requested: Faxed to: _____

Comments: _____

_____

Appointment Information:
Appointment Date: _____ Time:_____

Physician Assigned:_ _____ ❒ Peoria ❒ Pekin ❒ Galesburg ❒ Rockford
❒ Satellite _ _____

Patient has been notified of date and time: ❒ Yes ❒ No Date:_ _____

Referring Office Notified: Date Faxed:_____ Spoke to Date:_____

Information Packet Sent: ❒ Yes ❒ No Date:_ _____

Signed:_ _____ Date:_ _____