MEDICAL CONSULTATION FORM

Date of Medical Consultation Request: _____

To: _____ Re: _____
Patient Name

_____ _____
Date of Birth

_____

Our mutual patient has presented to my office, with the following medical condition(s):
_____
_____.

I have recommended the following treatment/procedure: _____
_____
_____.
_____ anesthesia is planned.
The procedure will be performed in a(n): ☐ Office Setting ☐ ASC ☐ Hospital.

After reviewing this patient's health history, my medical consultation questions to you include:
_____
_____
_____.

Please return this completed Medical Consultation Form by: (*date*_____) via _____ or other secure transfer method.

We greatly appreciate your input regarding our mutual patient's care. Please contact me directly with any question regarding this consultation request at (*phone number*).

Anthony J. Russo, DDS

Requesting Doctor's Signature Date

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PHYSICIAN'S RESPONSE

There are medical contraindications to the:

- proposed treatment/procedure? ☐ Yes ☐ No
- anesthesia plan? ☐ Yes ☐ No

If yes, what are they? _____

_____

_____

_____

Do you recommend any modifications to the patient's current prescribed medications related to the proposed procedure? ☐ Yes ☐ No
If yes, what are they? _____

_____

Are there any additional precautions you recommend to the proposed procedure? ☐ Yes ☐ No
If yes, what are they? _____

_____

Are there any lab test or additional testing you recommend before the proposed procedure? ☐ Yes ☐ No
If yes, what are they?_____

_____

☐ Please contact me directly with any question regarding this consultation request at: _____.

_____ _____
Medical Consultant Physician's Signature Date