

Consultation Request Form

When sending a patient to the office of Dr. Peters, we request that you complete this form and send any pertinent information to (Fax 319-337-9386) prior to your patients' evaluation in our office. If this is not possible, please give the patient a copy of this completed form with instructions to give to the receptionist.

Patient Name: _____

Patient Birth date: _____

Home Phone Number: _____

Physician Name: _____

Date of Request: _____

Reason for Request: _____

Appointment Date: _____ Time: _____

The physician requesting this opinion understands the consulting physician may initiate treatment or perform medically necessary treatment for this patient. The consulting physician will send the requesting physician an opinion and plan of care.

Physician Signature: _____ Date: _____