Consultation
Request/Report

Date : _____

Consult : _____

Requested By : _____

Diagnosis : _____

Reason for Consultation :

Medication(s)/Treatment(s) :

Consultation Findings

Findings : _____

Diagnosis :

Recommendations :

Follow-Up Date : _____

Signature : _____ Date: _____

Reviewed by Attending Physician

Comments :

Signature : _____ Date: _____

Resident Name:	Room #	Physician:	Medical Rec. #