



Request for Consultation:

Request Date: _____ Location: Lakeland Winter Haven

Patient Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ SSN: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Referring Physician Name: _____

Office Phone: () _____ Fax: () _____

UPIN _____ NPI _____

Requesting:

Consult and treatment

Consult only and return patient to above physician

Referral Number: _____ (if required)

Number of Visits Approved: 1 2 3 Other _____

Reason for consultation: _____

Comments: _____

Requesting Physician's Signature: _____

** Please fax this document back along with any pertinent medical records, patient demographics and a copy of the patient's insurance cards. Our office will forward a written report after treatment. **

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Phone: (863) 666-3436

Fax: (863) 667-3550

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