

OUTPATIENT CONSULT REQUEST from RVH Emergency Department

Date: _____

Consultant: _____

Patient: _____

URGENT CONSULT

☐ Consultant called

☐ Requested Time Frame

Reason for Referral:

Referring physician (print name): _____

Referring physician signature: _____

Billing number: _____

☐ Please fax all imaging studies and bloodwork from today's visit.

