CONSULTANT REFERRAL FORM

TO: ACCESS DUPAGE
Referral Department
Phone # (630) 510-8720
Fax # (630) 510-8707

DATE: _____

FROM: _____ _____
(Primary Care Physician name) **(Office Name and Phone Number)**

THE PATIENT BELOW NEEDS CONSULTATIVE CARE FOR:

_____

(Diagnosis/Complaint)

Please check all that apply : ❒ Recurrent ❒ Chronic ❒ Resistant to treatment ❒ Acute

Name:_____ ID:_____

Address:_____ Birth date: _____

City, State, Zip: _____ Telephone:_____

_____

(Type of Specialist Requested)

Has patient been treated by a specialist for this condition before? ❒ Yes ❒ No
If so, please provide name and location of prior specialist, if available:

_____

_____

_____

Please attach medical records and diagnostic reports relevant to this request and fax referral request to the referral department (630-510-8707). Thank you!

Access DuPage will contact both patient and PCP when referral is completed .

If you have any referral questions, please call 630-510-8720, ext. 213 (Marcella) or 218 (Ivelisse).
Se habla espanol.