

SAVANNAH VASCULAR INSTITUTE – REQUEST FOR CONSULTATION

Main (Waters Ave) Office: (912) 352-8346 / Fax: (912) 355-1414

Satellite Offices

Hinesville * Jesup * Rincon * Statesboro * Vidalia * Bluffton

Patient's Name: _____	Home Phone: _____
Address: _____	Work Phone: _____
_____	DOB: _____
E-mail: _____	SSN: _____
Person other than patient to arrange appointment (Name): _____	
Phone: _____	Relationship to patient: _____
<input type="checkbox"/> Medicare # _____	<input type="checkbox"/> Self Pay / Pt/Ref Dr notified of payment due
Insurance Plan: _____	ID#: _____
Address: _____	Prior Approval Needed: _____ Yes _____ No
_____	Authorization #: _____
Out of Network: Physician notified: _____	Patient Notified: _____
Consulting Physician: _____	Office Phone #: _____
Address: _____	Office Fax #: _____
_____	UPIN #: _____
Contact Person: _____	NPI #: _____
Physician Requested: *Avino *O'Kelley *Cohn *Dahn *Darden *Horesh *Wixon *Brown (Please Circle)	
*Mondy *Ellison *Nelson *Sussman *Walls *Moon *Any Physician Available	
Reason for Consultation:	
Chief Complaint:	
Pertinent Other Dx: Diabetes Hypertension Hyperlipidemia Other: (please circle)	
Patient should be seen: 24 Hours 72 Hours Within Week Next Available (please circle) If you have an Emergent request please contact our office at 629-7800 or 961-9753	
****WE MUST HAVE THIS INFORMATION IN ORDER TO MAKE AN APPOINTMENT**** WE WILL NOT MAKE ONE WITHOUT IT*****	_____ Last Two Office Notes _____ List of Current Medications _____ Any Testing Pertinent to Consult _____ Insurance Cards
Person completing this form: _____	Date/Time Received: _____
Notes: _____	

Appt Scheduled: Date: _____ Time: _____ Physician: _____	