SAVANNAH VASCULAR INSTITUTE - REQUEST FOR CONSULTATION

Savannah Office: 7208 Hodgson Memorial Drive: (912) 352-8346 / Fax: (912) 355-1414

Satellite Offices

***Hinesville * Jesup * Pooler * Statesboro * Vidalia * Brunswick * 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:

☐ Medicare # _____ ☐ **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 *Brown (PD) *Cohn *Dahn *Darden *Ellison *Horesh
(please circle) *Mondy *Moon (PD) *Nelson *Sussman *Walls (PD) *Wixon ***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: _____

_____

Appointment Scheduled: Date _____ Time: _____ Physician: _____