

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 * Okatie, SC**

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