MASSACHUSETTS GENERAL HOSPITAL

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SPECIALTY CONSULTATION REQUEST FORM

Please complete this form and fax to 617-724-2718 or email to mailto:lbringhurst@partners.org
The patient will be contacted directly to schedule an appointment.
The referring physician will be sent a fax with the date of the appointment and the scheduled provider.

Patient Contact Information

Name *(Last, First, M.I.):*	**MGH Blue Card#:**	☐	**Not registered, given RRC 866-211-6588**
Mobile phone			
Home phone			
Work phone			

Reason for Consultation Request

☐ **Referred by Physician**	**Name of referring physician**
☐ **Other**	**Please describe**

Referring Physician

Name		
Address		
City	**State**	**Zip**
Phone Number	**Fax**	

Other Healthcare Provider/s (including specialists)

Name		**Specialty**
Address		
City	**State**	**Zip**
Phone Number	**Fax**	
Name		**Specialty**
Address		
City	**State**	**Zip**
Phone Number	**Fax**	
Name		**Specialty**
Address		
City	**State**	**Zip**
Phone Number	**Fax**	

Report Distribution

To send written reports the healthcare providers you listed, or to discuss your case with them, we need your permission. Please list here all providers you listed above with whom you would like us to correspond. If you do NOT want reports sent to any/certain providers, please indicate this clearly as well.

Name	Would you like the whole report sent?	Comments
	☐Yes ☐No	
	☐Yes ☐No	
	☐Yes ☐No	
	☐Yes ☐No	