



**The Vancouver Clinic Consultative Request Form**  
FAX 360-604-1725

Date: \_\_\_\_\_

Specialty Requested: \_\_\_\_\_ Requested Provider: \_\_\_\_\_

Request for:  Consultation advice/opinion/assistance about care for patient below  
 Transfer of care and management of the below stated indication  
for this patient

Specific concerns/indications (Diagnosis/Symptoms):

\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ Phone (Work): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance information: \_\_\_\_\_

Authorization number: \_\_\_\_\_ Dates valid: \_\_\_\_\_ Visits covered: \_\_\_\_\_

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Referring Physician: \_\_\_\_\_ Clinic name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact name: \_\_\_\_\_