Urology of Central Pennsylvania, Inc.

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REQUEST FOR OPINION

Dr. _____ is requesting an opinion on
(Requesting Physician's Name)

_____ _____
(Patient Name) (DOB)

A request for an opinion and consultation for the above named patient has been made from the above named physician. This patient has been sent to UROLOGY OF CENTRAL PENNSYLVANIA, INC. for the following reasons:_____

_____

_____

_____

The physician requesting this opinion understands that the consulting physician may initiate treatment or perform medically necessary diagnostics for this patient. The consulting physician will send the requesting physician an opinion and plan of care.

_____
(Requesting Physician's Signature)

[ ] Please call patient at _____ to schedule appointment.
(Pt phone number)

UCPA will fax form back to _____ to confirm the appointment date and time.
(office fax number)

Appointment Date & Time_____ with Dr._____ at

_____.
(appointment location address)

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