



## CONSULTATION NOTE

Patient Information			
Name:	Date:	DOB:	MRN:
Consulting Provider:		Referring Provider:	
Consultation Request & Purpose			
Reason for Consultation:		Specific Request from Referring Provider:	
Relevant Medical History & Reports			
Key Diagnoses:		Current Medications:	
Pertinent Labs/Imaging		Recent Interventions:	
Assessment & Clinical Reasoning			
Clinical Summary:		Differential Diagnosis:	
Recommendations & Next Steps			
Diagnostic Recommendations:			
Treatment Plan:			
Follow-Up Instructions:		Referral(s):	
Availability for Follow-Up?:			
Follow-Up: <input type="checkbox"/> One month <input type="checkbox"/> Three months <input type="checkbox"/> Six months <input type="checkbox"/> One year <input type="checkbox"/> As needed <input type="checkbox"/> Pending tests			
Signature:		Date:	