CENTRAL OHIO PRIMARY CARE

Westerville Medical Associates

CONSULTATION REOUEST FORM

Endocrinologist:	**Reason for Consultation:**
John E. Paes, D.O. Westerville Medical Associates 285 West Schrock Rd Westerville, Ohio 43081 Phone: (614) 818-9550 Fax: (614) 818-9556	☐ Thyroid ☐ Pituitary ☐ Adrenal ☐ Other_____ ☐ Diabetes ☐ Type 1 ☐ Type 2 ☐ First Available ☐ Urgent/how soon _____

PATIENT INFORMATION

Patient Name:		**DOB:**	
Insurance:	**(Aetna referral Auth:**	**#Visits:**	**)**
Phone: home	cell	work	
Address:	**City**:	**State:**	**Zip:**

REFERRING PHYSICIAN INFORMATION

Physician Name:		**NPI #**	
Practice Phone:	**Fax:**	**Email:**	
Practice Address:	**City:**	**State:**	**Zip:**

Please note: An appointment will be scheduled when this form is completed, then faxed or emailed with corresponding office notes, labs, prior imaging. Upon receipt of the information this office will contact the referring office to schedule the appointment and notify the patient of the appointment. Failure to receive your records may result in your patient not being seen.

Appointment Date: _____ Time _____

Date faxed to Referring Physician: _____
Faxed by: _____