

Patient Information

Patient Name _____ Date _____

DOB _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Diagnosis/Reason for Consult _____

** Please include a copy of the patient's demographics, insurance information and office notes from last visit:*

Physician Consult Request **If unassigned, please select preferred location below:*

- | | | |
|--|---|---|
| <input type="checkbox"/> Mary Bergh, MD | <input type="checkbox"/> Lee Padove, MD | <input type="checkbox"/> Feresa Weragoda, MD |
| <input type="checkbox"/> Courtney Bess, MD | <input type="checkbox"/> Amit Tibrewala, MD | <input type="checkbox"/> An Young, MD |
| <input type="checkbox"/> Parham Eshtehardi, MD | <input type="checkbox"/> Deepthi Tirunagari, MD | <input type="checkbox"/> Christine Becker, NP |
| <input type="checkbox"/> Keionna Grant, MD | <input type="checkbox"/> Michele Voeltz, MD | <input type="checkbox"/> Unassigned |

Preferred Location

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> Atlanta | <input type="checkbox"/> Cumming | <input type="checkbox"/> Peachtree Corners |
| <input type="checkbox"/> Buford | <input type="checkbox"/> Duluth | <input type="checkbox"/> Roswell |
| <input type="checkbox"/> Canton | <input type="checkbox"/> Lawrenceville | <input type="checkbox"/> Snellville |

Referring Provider Information

Provider Name _____

Provider Contact # _____

Provider Fax # _____

Appointment Priority

- ☐ Urgent (1-2 Business Days) Within
- ☐ 5-7 Business Days
- ☐ 1st Available to Establish Care

Patient Appointment

Date _____

Time _____

Provider _____

Location _____

Additional Notes