URGENT: ☐ Yes ☐ No

MEDICAL CONSULTATION

Name of establishment


DT9065

Consultant/service

Referring/physician

Service requested

☐ Consultation ☐ Consultation and transfer
☐ Consultation and concurrent care ☐ Consultation Pre-op

Clinical data and reasons for the request

Date Year Month Day Time :

Referring physician Signature License No.

Request transmitted to by:

Date Year Month Day Time :

CONSULTANT'S REPORT

If you are dictating this report, please make an entry in the progress notes containing your diagnostic impression and any recommendations of immediate concern to referring physician.

Year Month Day
Date Time :

IF INSUFFICIENT SPACE use form AH-600 DT or AH-601 DT titled "Suite de rapport".

Signature of consultant and license No.

Imprimé sur du papier recyclé

URGENT: ☐ Yes ☐ No

MEDICAL CONSULTATION

Name of establishment

DT9065

Consultant/service

Referring/physician

Service requested

☐ Consultation ☐ Consultation and transfer
☐ Consultation and concurrent care ☐ Consultation Pre-op

Clinical data and reasons for the request

Date Year Month Day Time :

Referring physician Signature License No.

Request transmitted to by:

Date Year Month Day Time :

CONSULTANT'S REPORT

If you are dictating this report, please make an entry in the progress notes containing your diagnostic impression and any recommendations of immediate concern to referring physician.

Year Month Day

Date Time :

Signature of consultant and license No.

Imprimé sur du papier recyclé

URGENT: ☐ Yes ☐ No

MEDICAL CONSULTATION

Name of establishment

Consultant/service

Referring/physician

Service requested

☐ Consultation ☐ Consultation and transfer
☐ Consultation and concurrent care ☐ Consultation Pre-op

Clinical data and reasons for the request

Date Year Month Day Time : | **Referring physician** | Signature | License No.

Request transmitted to | by: | **Date** Year Month Day Time :

CONSULTANT'S REPORT

If you are dictating this report, please make an entry in the progress notes containing your diagnostic impression and any recommendations of immediate concern to referring physician.

Year Month Day

Date Time :

Signature of consultant and license No.

Imprimé sur du papier recyclé

URGENT: ☐ Yes ☐ No

MEDICAL CONSULTATION

Name of establishment

DT9065

Consultant/service

Referring/physician

Service requested

☐ Consultation ☐ Consultation and transfer

☐ Consultation and concurrent care ☐ Consultation Pre-op

Clinical data and reasons for the request

Date	Year	Month	Day	Time :	Referring physician	Signature	License No.

Request transmitted to	by:	Date	Year	Month	Day	Time :

AH-226A DT (rev. 04-10)

MEDICAL CONSULTATION

PERSON TO WHOM THE REQUEST IS ADDRESS