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**Connie Strey, PT**

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### Referral Request

Date of Request: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Contact Phone #(s): (H) \_\_\_\_\_ (Cell) \_\_\_\_\_ (W) \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Reason for Consultation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Notes:

Referring Provider's Signature: \_\_\_\_\_

**Fax completed form and requested pertinent medical records to:**

**(920) 831-8334**

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Due to new requirements by CMS, we ask that you please complete this form for consultations. Effective January 1, 2006, CMS updated its requirements for physician consultations. Please view the link below for more detail, specifically Section II Medical Consultations A. Consultation Services vs. Other Evaluation and Management (E/M) Visits.  
<http://www.wpsmedicare.com/policies/wisconsin/phys006.pdf>