3913 W. Prospect Avenue, Suite LL2
Appleton, WI 54914
Phone: (920) 729-2982
Fax: (920) 831-8334
www.ptcenterforwomen.com

Consultation Request

❑ **Connie Strey, PT, BCB-PMD, WCS** ❑ **Michelle Landsverk, PT, DPT**

Date of Request: ____________________

Patient Name: ____________________

DOB: ____________________ Contact Phone #(s): ____________________

Referring Physician: ____________________ Phone #: ____________________

Reason for Consultation: ____________________

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LMP: ____________________ EDD: ____________________

Notes:

Referring Provider's Signature: ____________________

Fax completed form and requested pertinent medical records to:
(920) 831-8334

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