



# Castle Family Health Centers Telemedicine Clinic

Telephone# (209)381-2000 Fax# (209)381-2010

**CONSULTATION/ REFERRAL REQUEST**

**DATE:** \_\_\_\_\_

**From:** \_\_\_\_\_

**Referring Provider's Name:** \_\_\_\_\_ **Contact Name:** \_\_\_\_\_

**Provider's Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **NPI#** \_\_\_\_\_

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**New Patient**       **Follow-up Patient**

**Specialty Requested:** \_\_\_\_\_

**Reason for Referral** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Patient Information**

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Social Security#:** \_\_\_\_\_

***Please attach all pertinent medical records and insurance info to this request for review.***