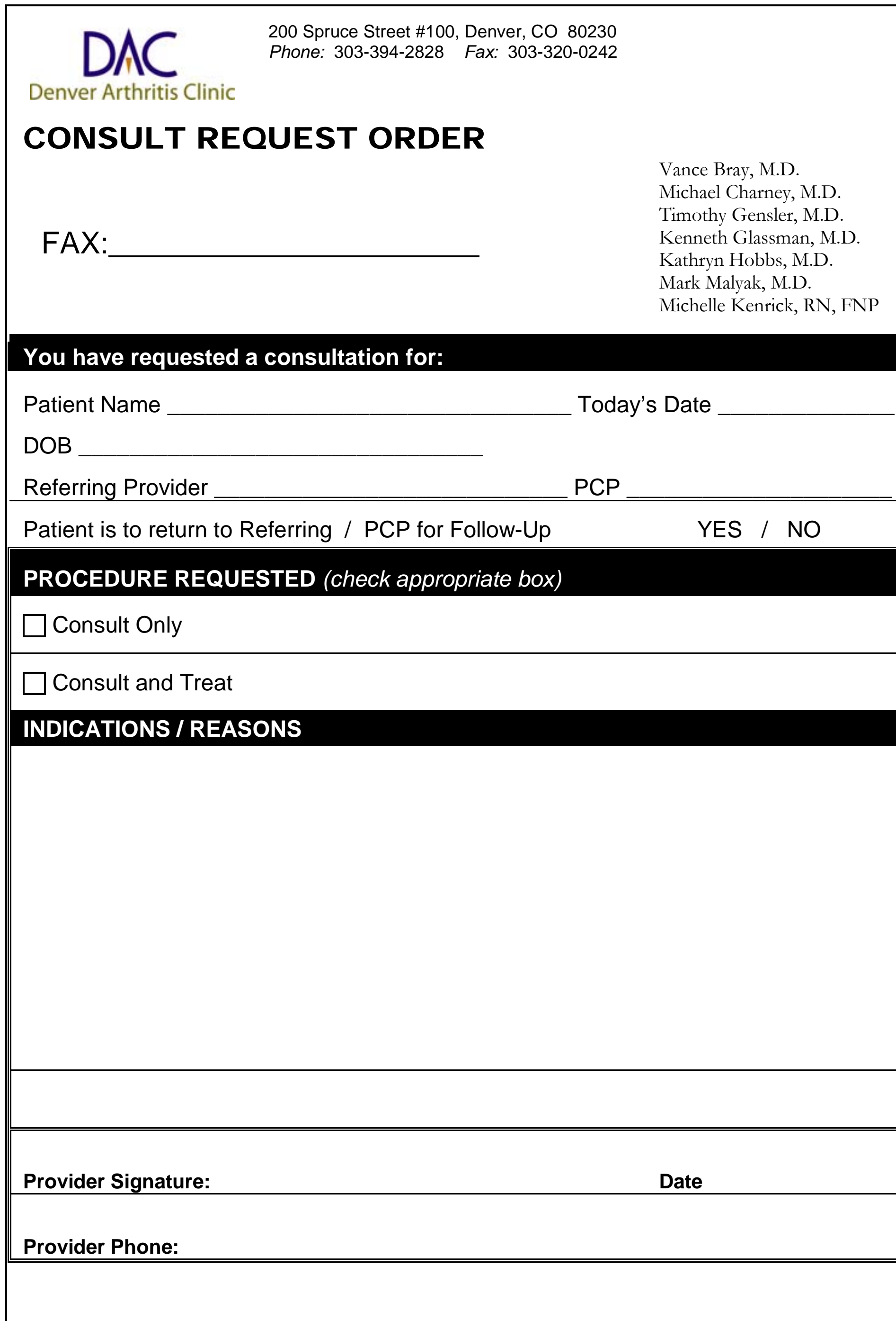
We have scheduled the appointment with Dr. ____________ on ________/_____/______.



Denver Arthritis Clinic

200 Spruce Street #100, Denver, CO 80230
Phone: 303-394-2828 *Fax:* 303-320-0242

CONSULT REQUEST ORDER

Vance Bray, M.D.
Michael Charney, M.D.
Timothy Gensler, M.D.
Kenneth Glassman, M.D.
Kathryn Hobbs, M.D.
Mark Malyak, M.D.
Michelle Kenrick, RN, FNP

FAX:________________________

You have requested a consultation for:

Patient Name ________________________________ Today's Date ______________

DOB ________________________________

Referring Provider ____________________________ PCP _____________________

Patient is to return to Referring / PCP for Follow-Up YES / NO

PROCEDURE REQUESTED *(check appropriate box)*

☐ Consult Only

☐ Consult and Treat

INDICATIONS / REASONS

Provider Signature: **Date**

Provider Phone:

ATTN: MEDICAL RECORDS

After consult above is sign by physician, please fax this form along with the following information to us at **303-320-0242**.

- Recent lab work
- X ray reports
- Recent office notes