DOCTOR-PATIENT COMMUNICATION FORM:
TEST, APPOINTMENT OR CONSULTATION INSTRUCTIONS

There are things that both you and your doctor can do to help take care of you. The following is being provided to you so that you understand what is being recommended for you.

Tests

❑ Test (Routine): _____

_____

By (Date): _____

❑ Test (For Problem): _____

_____

By (Date): _____

❑ Other: _____

_____

By (Date): _____

❑ An appointment has been made for you with:
Facility Name:

_____

For:

_____

Date:_____ Time:_____

Referrals/Consultations

❑ Go to a physician in the specialty of _____
for the following condition(s):_____

_____

Suggested Physician(s):_____
(You may also see another physician of your choice or use any physician from the list provided)

❑ An appointment has been made for you with the physician:

Physician Name: _____

Date:_____Time: _____

Telephone:_____

Address:_____

_____

<Physician/Group Name> <Address> <Telephone & Fax>

Follow-Up

- ❑ Return to our office for a follow-up appointment by: _____
- ❑ Your follow-up appointment at our office has been scheduled for:
  Date:_____
  Time: _____
  (Please call the office to make another appointment if you are unable to make the scheduled date and time.)
- ❑ Make sure that all test results and referral reports are sent to our office:
- ❑ Ordered Tests: _____
- ❑ Consultant Physician's Report: _____
- ❑ If you have not heard from us, call to discuss your test results with your doctor within _____ weeks after you have taken the test or have visited the surgeon.
- ❑ Call our office if your symptoms continue and/or if you notice any changes.

Educational Information

- ❑ I have been given the opportunity to ask questions about my condition and recommended instructions.
- ❑ I understand my doctor's recommendations and instructions given to me.
- ❑ I agree to follow my doctor's recommendations and instructions given to me.
- ❑ I do not agree to follow my doctor's recommendations and instructions given to me. The risks of not following the recommended treatment plan have been explained to me and I have had the opportunity to ask questions. I understand the potential consequences of not following my physician's instructions.

Patient Name: _____

Signature:_____ Date: _____
(or authorized representative)

Relationship to Patient: _____