Date:___________________________________ No. of pages:

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To: Keturah Health, LLC   Fax: 877-705-7282   Email:

keturahnp@keturah-hms.com

From:___________________________________ Title:

____

Phone:__________________________________

Fax:______________________

PATIENT INFORMATION

Name of patient:

__________________________DOB:_____________________ Interpreter

needed: Yes   No   Language: _______________________

Home

phone:____

Address:______________________ City:

_______________Zip:______________

Insurance: Include a copy of patient's insurance card (both sides), demographic sheet and HMO authorization if required. Most recent H&P or progress note which include current diagnosis medication requisition, face sheet, wound pictures if available.

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By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION
Referring Clinician:_________________________

Specialty:________________

Phone:__________________________________

Fax:_____________________

Signature:____
_ NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated