Golden Rule Services, Inc.
Phone: (281)-997-2295
Fax: (281) 997-2835

Physician Consult Form

Appointment Date: _____ **Appointment Time:** _____

Assigned Staff: _____ **LCN:** _____

Consumer Information:

Name: _____ **DOB:** _____

Allergies: _____

Type of Visit:

☐: Primary Care ☐: Psychiatry ☐: Vision ☐: Cardiology

☐: Neurology ☐: Podiatry ☐: ENT ☐: Other _____

Physician Information:

Name: _____

Address: _____

Phone: _____

Reason for Consultation:

_____

Findings, Recommendations, and Treatment:

_____

_____

_____

Please document the patient's B/P _____/_____ **and WEIGHT** _____

PHYSICIAN SIGNATURE: _____

PRINTED NAME: _____ **DATE:** _____

NEXT APPOINTMENT: _____ **TIME:** _____
MONTH/DATE **DAY OF WEEK**

GRSI OFFICE USE ONLY

GRSI NURSE'S SIGNATURE: _____ **DATE:** _____