To David Siegler, M.D.

Fax Request for:

☐ **Pediatric Neurology Consultation**
☐ **EEG**

Date: ______________________________

PATIENT NAME ______________________________________

Date of Birth __________________ **Age** _______________

City ______________________________________ **State** ____________________________________

Insurances (1) ______________________________________ **Insurance (2)** ____________________________________

Legal Guardian: ______________________________________ **Relationship:** ____________________________________

Contact #'s: ______________________________________

Authorization #: ☐ **not needed** ☐ **obtained (will be faxed)** ☐ **not yet obtained**

Referring Dr: ______________________________________ **Phone**_____________________ **Fax**____________________

Dr's Reason for Consult: ____

Brief Summary of Child's Issue: ____

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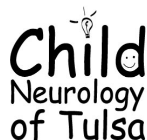
Urgency of appointment: ☐**Next Available** ☐**Next 1-2 Weeks** ☐ **ASAP: Please call Dr. Siegler (918) 493-7222 (Dr's line)**

Person and position of person filling out form: ____

____**M.D. / D.O. / ARNP**
Requesting Physician/Clinician Signature

Revised 01-09-12



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