



**Request for Physician Services—  
Park Nicollet Alexander Center**



118025MEDCON

NAME:	
DOB:	
MR#:	HCL# :
LABEL or ADDRESSOGRAPH	

**Fax completed form to 952-993-2505 within five days**

You have requested a consultation for \_\_\_\_\_ by a provider at Park Nicollet Alexander Center, for child development and behavior. Please return the completed fax within five days.

The new Medicare guidelines for consultation services, effective Jan. 1, 2006, require that the intent of referral be clearly documented in the requesting physician's medical record and also in Park Nicollet Health Services' medical record. These guidelines also apply to the other health insurers. Medicare requirements stipulate that **you must retain a copy of this document for your records.**

**Reason/Indication (required)**

\_\_\_\_\_

**Select one category**

- I need a consultation (advice, opinion, assistance) about care for the above patient.
- I want you to take over evaluating and managing of the above stated indication for this patient instead of me (new patient referral, not consult).

Thank you for providing us the opportunity to share in the care of your patient.

\_\_\_\_\_  
Requesting physician or other health care provider's name

\_\_\_\_\_  
Provider's signature

\_\_\_\_\_  
Date

Park Nicollet Alexander Center phone number: 952-993-2498

**Fax completed form to 952-993-2505**