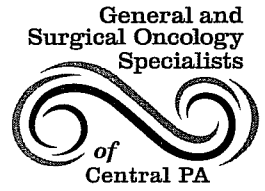


**CONSULTATION REQUEST**



General and Surgical Oncology Specialists of Central PA  
233 College Ave, Suite 203  
Lancaster, PA 17603

717-735-9190 fax  
717-735-9187 phone

Facility requesting: \_\_\_\_\_

Phone number: \_\_\_\_\_

Date: \_\_\_\_\_

Requesting Physician & Signature \_\_\_\_\_

Appointment Type:  
Consult & Treat \_\_\_\_\_ Urgent 24-48 Hours \_\_\_\_\_ Non-Urgent \_\_\_\_\_

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Physician: \_\_\_\_\_ Robert L. Conter, M.D.

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Patient Name: (print please)

\_\_\_\_\_  
(first) (middle initial) (last)

Date-of-Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Mo Day Year

Insurance: Primary - \_\_\_\_\_ ID# \_\_\_\_\_

Secondary - \_\_\_\_\_ ID# \_\_\_\_\_

Please fax the insurance REFERRAL if required, AND also a COPY OF THE PATIENT'S INSURANCE CARD to: 717-735-9190.

**Clinical Information:**

**Symptoms/Reason for Consultation:**  
(please specify LEFT, RIGHT or BILATERAL when applicable)

\_\_\_\_\_  
\_\_\_\_\_

Please ask the patient to bring a list of their MEDICATIONS, INSURANCE CARD(S), X-RAY FILMS, MRI FILMS, CT FILMS and other pertinent DIAGNOSTIC STUDIES along with them to their appointment.  
We will contact the patient and will advise you when the appointment has been scheduled.  
Thank you for allowing me to assist in the care and treatment of your patient.