

CONSULTATION REQUEST

Date _____ File No. _____

Name Of Facility Address Of Facility

Person To Be Contacted Telephone No.

Consultant Service Requested

- Nursing
- Occupational Therapist
- Nutrition
- Medical
- Physical Therapist
- Other (Specify) _____
- Pharmaceutical
- Medical Records _____

Program Involved

- Licensing
- Medi-Cal
- Medicare

Problem Description

Action Involved

- Survey Report held pending Consultation Report
- Please contact originator before visiting
- No special handling

District Originator Telephone No.

Consultant's Action: _____ Date _____

- Visit scheduled _____
- Need to discuss further