LUCAS
RESEARCH
www.LucasResearch.org

CONSULTATION REQUEST FORM

*Patient's Name: ____

*Patient's DOB: ______________ *Insurance: ________________________

*Mailing Address: ____

*City: ___________________________ *State: _______ *Zip: __________

* Home Phone: (________)______________________________ Primary? ☐

* Cell Phone: (________)______________________________ Primary? ☐

*Email: ____

*Referring MD: _________________________ *Fax: __________________

*Reason for Consultation Request / Diagnosis:___________________________

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- ❑ Please check if patient is interested in participating in Diabetes Clinical Research

Please fax this consultation request form, along with the documents listed below, to **(252) 222-5705**.

- ❑ Most recent office notes and ALL labs pertaining to patient's diagnosis
- ❑ All x-rays pertaining to the diagnosis for which the patient is being referred
- ❑ Tricare Authorization, if applicable

We will schedule the first available consultation and relay the appointment back to your office.

** **Please inform the patient of their appointment date and time. Thank you.** **

**Note that DEC is not responsible for contacting the patient regarding their appointment information.*

For DEC Office Only

APPOINTMENT DAY AND TIME: ___________________________________

APPOINTMENT LOCATION: ______________________________________

PROVIDER: ____

Please make patient aware that we will mail them paperwork to be completed and returned to clinic prior to their appointment.