



PALs Developmental Center

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Consultation Request Form

Requesting Physician

Physician: _____ NPI#: _____ Date: _____

Physician Address: _____ City: _____ State: _____ Zip: _____

Contact Person: _____ Office #: _____ Ext: _____

Are you the PCP for this patient? YES NO If not who is: _____

Referral Contact Name: _____ Office#: _____ Ext: _____

Referral Contact Email Address: _____ @ _____

Patient Information

Patient: _____ Age: _____ DOB: _____

SSN: _____ - _____ - _____ Sex: M F Phone: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Policy #: _____ Group#: _____

*****Please attach a copy (front and back) of the insurance card*****

Diagnosis _____

Reason for Consult: _____

PLEASE send a copy of recent office visit.

***** Office Use *****

Appointment Date: _____ Time: _____

Insurance Verified by: _____ Date: _____

Patient Notified by: _____ Date: _____

New Patient Paper Work Mail out by: _____