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## REQUEST FOR CONSULTATION

Today's Date:

| To: Provider | Phone | Fax | e-mail |
|--------------|-------|-----|--------|
|              |       |     |        |

| Patient Name | Date of Birth | Contact Phone # |
|--------------|---------------|-----------------|
|              |               |                 |

Reason for consultation:

  
Jay B. Krasner, MD, FACP