

Request for Patient Information

Dear Doctor:

To ensure proper coordination of medical services to our mutual patient, we are requesting that you complete and return this form to us. Thank you for your assistance.

Required Medical Information

To: Primary Care Physician

Physician's Name:			
Clinic Name:		Phone: ()	
Address:	City:	State:	Zip Code:

Re: Patient

Patient Name:		Birthdate: / /	
Date of Last Physical: / /		Does Patient have another appointment: Yes No Date: / /	
List of Current Medications:		Dosages:	
_____		_____	
_____		_____	
_____		_____	

*** Please include a copy of most recent test results (if applicable)**

**Send to: Dr. Vladimir Vandalov
Renaissance Therapy Clinic
28336 Franklin Road
Southfield MI 48034-5503**

_____ Patient/Guardian Name (Print)	_____ Patient Signature	_____ Date
_____ Vladimir R. J. Vandalov, PsyD., LPC, NCC Therapist	_____ Therapist Signature	_____ Date
_____ Physician's Name (Print)	_____ Physician's Signature	_____ Date

Thank you for assisting us with our patient's treatment.