Physician Request for Consultation
for Online Consult Form

Physician: ___________________________________
Specialty: ___________________________________
Jurisdiction Licensed In: ___________________________________
Patient Name: ___________________________________

I am a physician licensed to practice medicine in the above jurisdiction. On behalf of my patient, who consents to this request, I am requesting an online consult from a physician who is on the medical staff at the H. Lee Moffitt Cancer Center & Research Institute Hospital, Inc. ("MCC"). I understand that the service being provided by the MCC physician is an online consult only and that my patient will remain under my direct care. I acknowledge that the online consult report will be sent directly to the fax number I am supplying below.

Physician's Signature: ______________________________________

Date: ______________________________________

Physician's Information:

Fax: ____

Phone Number: ____

Email Address: ____

Mailing Address: ____

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