

# NRP Consultation or Test Request Form



John H. Stroger, Jr. Hospital  
of Cook County  
1900 W. Polk Street, Chicago, IL 60612. 312 864-6000

Date: \_\_\_\_\_

ATC#: \_\_\_\_\_

Patient Name:

\_\_\_\_\_  
Last First MI

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone Number DOB

Referring Clinic: Access to Care - \_\_\_\_\_

Phone #: \_\_\_\_\_

Name of Referring Physician: \_\_\_\_\_

(print)

Phone #: \_\_\_\_\_

**TO BE COMPLETED BY REFERRING PROVIDER/ PHYSICIAN:**

This is a request for: Specialty Consult: \_\_\_\_\_

Test: \_\_\_\_\_

**Patient History (such as: DM, HTN). Include pertinent physical findings:**

**Specific Indication for Referral/Test:**

**Positive Laboratory Data:**

**Provider/Physician Signature:** \_\_\_\_\_