



Request Form for Midwest Surgical Center Consultation

To: Midwest Surgical Center
PO Box 11285
Champaign, IL 61826-1285

Referral Date: _____

From: Referral M.D. or Referral Agency _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone: _____ Patient Email: _____

Request/Procedure (reason for consultation or reason for referral): _____

Diagnosis and/or Problem: _____

Other Pertinent Information: _____

Please send consultation report to: Midwest Surgical Center
PO Box 11285
Champaign, IL 61826-1285

Patient Information

You should contact Midwest Surgical Center directly to confirm appointment time and schedule. By accessing our website at www.midwestsurgicalcenter.com under "Contact/Insurance", you can obtain information regarding preferred provider insurance plans, commercial or traditional insurance plans, and payment policies.

I hereby authorize Midwest Surgical Center and Dr. Suzanne Trupin to release the above information and the results of the findings. I understand that it is my responsibility to keep the above appointment or cancel if necessary. I realize that failure to do so may exclude me from eligibility for future appointments with the referral agency or provider.

Patient's Signature: _____

Date: _____