



Children's North Surgery Center
PCP Consulting Form

Date _____

Via Facsimile: _____

PCP Info:

Name _____

Address _____

Phone _____

Fax _____

<p>To: _____</p> <p><input type="checkbox"/> Original to follow</p>

Dear Dr. _____,

_____ is scheduled to have a _____
(Patient's name/ Birthdate) (Procedure name)

_____ performed at the Children's North Surgery Center on

_____. The Department of Health requires the surgeon to notify and seek
(date)
an opinion from the Primary Care Physician regarding the appropriateness of the use of the
facility for the proposed procedure.

To assure compliance with the regulation, please indicate your approval/
Dis-approval by marking the appropriate box below and faxing this signed form to Children's
North Surgery Center at 724-933-3741. If you have any questions or comments, please do not
hesitate to contact me at (phone #) 724-772-3388 or the North Surgery Center at 724-933-
3700.

_____ I accept the judgment of the surgeon/attending physician.

_____ I do not agree with the performance of the above-referenced procedure at the ASF
for this patient because _____

Thank you for your attention to this matter.

Sincerely,

Surgeon name

Primary Care Physician Signature/Date _____