Children's North Surgery Center
PCP Consulting Form

Date ____________________ ***Via Facsimile:*** ________________

PCP Info:
Name ____________________
Address ____________________
Phone ____________________
Fax ____________________

To: ____________________________

☐ Original to follow

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____________________________

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Thank you for your attention to this matter.

Sincerely,

Surgeon name

Primary Care Physician Signature/Date ______________________________