



Second Opinion Examination

You have been referred to our office for a 2ND Opinion Examination. We appreciate the opportunity to be involved in your case. In this type of appointment, the doctor will determine if she is able to provide the care you need. If a determination is made that the doctor will be providing treatment, treatment may begin at the time of your initial appointment. At the request of _____, an examination will be performed and full medical history obtained from you. The doctor will then review the medical records that have been provided.

Your examination is specifically for the assessment and possible treatment of your medical problem as it relates to your injury and/or impairment. A 2nd Opinion Examination is not meant to be a substitute for routine medical care with your primary care physician.

By signing this form, I authorize an examination by Dr. Wheeler.

THANK YOU FOR YOUR COOPERATION.

Patient Name: _____
(Please Print)

Patient Signature: _____

Date: _____

Witness: _____