

## Medical Consultation Day *Requesting an Appointment*

Appointment is for (name) \_\_\_\_\_

Check one:    Adult \_\_\_\_\_  
                  Child \_\_\_\_\_            Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

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

E-mail \_\_\_\_\_

Appointments will be 20 minutes long.

When are you available? (Pick one)

All day \_\_\_\_\_    Morning only (8:30am–12:00pm) \_\_\_\_\_    Afternoon only (1:30 pm– 3:00 pm) \_\_\_\_\_

Which Specialists do you wish to see? You may choose up to 3.

\_\_\_\_\_ Adult Health

\_\_\_\_\_ Dental

\_\_\_\_\_ Genetics

\_\_\_\_\_ Hearing

\_\_\_\_\_ Mental Health

\_\_\_\_\_ Nutrition

\_\_\_\_\_ Pulmonary

\_\_\_\_\_ Pediatric Surgery

\_\_\_\_\_ Physical Therapy

\_\_\_\_\_ Women's Health

\_\_\_\_\_ Pain

Please return this form to the OI Foundation by emailing [bonelink@oif.org](mailto:bonelink@oif.org).