Practicing Excellence
Setting the Standard.

PHYSICIAN REFERRAL FOR CONSULT TO ENT ASSOCIATES

☐ENT Associates to call the patient to schedule

☐The patient will call ENT Associates to schedule

☐Our office has already scheduled the patient with ENT Associates

Requesting Physician:____

Address:_______________________ **City:**_______________ **State:**_____ **Phone:**_______________

SCHEDULE WITH:

☐ Thomas Herendeen, MD	☐ Mohan Rao, MD	☐ Nicole Seabeck, NP
☐ Brian Herr, MD	☐ Deepkaran Reddy, MD	☐ Brandon Emry, NP
☐ Adam Kaiser, MD	☐ Stephen Schreck, MD	☐ Heidi Hesseling, NP
☐ Amy Lai, MD	☐ David Stein, MD	☐ Tiffany Witte, NP
☐ Douglas Nuckols, MD	☐ Edward Westfall, MD	☐ Rob Ribber, NP
☐ Paul Porter, MD	☐ Sreeya Yalamanchali, MD	☐ Josh Holley, NP
☐ Gaurav Prasad, MD	☐ Maria Ambush, NP	☐ Decoma Cavender, NP
		☐ Michelle Salisbury, NP

Reason for Consult:____

Patient Name:__________________________________**Patient Date of Birth:**__________________

Patient Contact Phone #:__________________**Contact Name, if other than Patient:**________________

Prior Authorization Number, if applicable:____________________

Please include the following with this form:

☐ **Patient Demographics and Insurance Info** ☐**Copies of Pertinent Office Visits and Diagnostic Tests**

Please Fax to ENT Associates: (260) 423-9677 or (260) 484-3309

APPOINTMENT CONFIRMATION INFORMATION

SCHEDULED WITH:____

LOCATION:____

APPOINTMENT DATE:____