CAROLINA EAR NOSE & THROAT SINUS AND ALLERGY CENTER, P.A.

PROVIDER REFERRAL REQUEST FORM

REFERRING TO

Practice Name: Carolina ENT-Sinus and Allergy Center	Phone: 828-322-2183	Fax: 828-485-2799 or 828-322-7279 Email: referrals@carolinaearnosethroat.com

Please Schedule (select all that apply):

☐ Preferred Location: ☐ Hickory ☐ Lincolnton ☐ Morganton

☐ Preferred Physician: ☐ Dr. Harrill ☐ Dr. de Neef ☐ Dr. Jarrett ☐ Dr. Cost

☐ Dr. Melon ☐ Dr. Hendricker ☐ Dr. Falls ☐ Dr. Zanation

☐ Urgent-- Referring physician called ______________________________

☐ Routine Appointment: ______________________________

Referring Provider's Name:	Phone:	Fax:

TYPE OF REFERRAL

☐ Evaluation consultation with treatment recommendations that primary care physician will continue to follow

☐ Evaluation consultation with assumed care for this condition

☐ Evaluation consultation with treatment recommendations and shared care

☐ Specialist to Specialist*–Secondary Referral
*Send copy of this referral to patient's primary care physician.

☐ Other (designate)______________________________

PATIENT INFORMATION

Patient Full Legal Name:		DOB
If patient is under 18 years old – Parent Contact Name:		
Address:	Email:	
Preferred Phone:	Best time to call:	
Special Patient Considerations:		
Patient Insurance Company: Subscriber Name:	Policy #: Authorization # (if applicable):	Group # # of visits:
Patient's Primary Care Provider:	Phone:	Fax:

GENERAL INFORMATION

Reason for Referral:

Comments/Considerations Related to Referral: **Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes. **

Patient aware of reason for referral? ☐ Yes ☐ No: Explain