PROVIDER REFERRAL REQUEST FORM

REFERRING TO

Practice Name: Carolina ENT-Sinus and Allergy Center	Phone: 828-322-2183	Fax: 828-322-2389

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. Mauldin ☐ Dr. Hendricker

☐ 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:	
Preferred Phone:	Best time to call:
Special Patient Considerations:	

Patient Insurance Company: Policy #:
Subscriber Name: Authorization # (if applicable): # 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

PROVIDER REFERRAL CONFIRMATION

REFERRAL CONFIRMATION

Referral Accepted? ☐ Yes ☐ No: Explain

Appointment Scheduled with:	Date & Time:

☐ Patient refused scheduling ☐ Patient prefers to contact specialist to schedule at a later date

Request for additional supporting clinical information (please detail):

Person completing confirmation:	Date of Confirmation: