ENT™

EAR, NOSE & THROAT ASSOCIATES, P.C.

FAX

TO: _____ **FROM:** _____

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RE: _____

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

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(260) 426-8117 • entfortwayne.com • contact@entfw.com

10021 Dupont Circle Court, Fort Wayne, IN 46825

ENT™

EAR, NOSE & THROAT ASSOCIATES, P.C.

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
☐ Brian Herr, MD
☐ Adam Kaiser, MD
☐ Douglas Nuckols, MD
☐ Paul Porter, MD
☐ Kumar Prasad, MD
☐ Deepkaran Reddy, MD
☐ Stephen Schreck, MD
☐ Nizar Taki, MD
☐ Edward Westfall, MD
☐ Sreeya Yalamanchali, MD
☐ Haley Hines, PA
☐ Emily Ritzert, PA
☐ Jeena Thomas, PA-C
☐ Kelley Christoffel, NP
☐ Heidi Hesseling, NP
☐ Josh Holley, NP
☐ Nicole Seabeck, NP
☐ Tiffany Witte, 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:_____

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