HILLS E·N·T
I N S T I T U T E

David P. Schleimer, D.O.

Physician Referral Request

Thank you for choosing to refer your patient to us. To start the referral process, please complete this form and fax it to our office.

REFERRAL FAX: (248) 268-0179

Referring Provider Information

Referred by Dr. ______________________________ Medical Group: ____________________________________

Telephone: _____________________ Fax: ____________________ PCP: _______________________________

Address: _________________________________ City: ______________________ State: ______ Zip: _________

This form was completed by: _____________________________________ Date: __________________________

Patient Information

Patient Name: ____ Birthdate: ____________ Sex: __M __F

Address: _________________________________ City: ______________________ State: ______ Zip: _________

Patient Telephone: _____________________________ Patient Cell Phone: _______________________________

Reason for Referral

Diagnosis: ____

Type of service requested: *(select one)*

Evaluation ____ Treatment _____ 2nd Opinion _____

Patient needs to be seen: *(select one)*

Immediately _____ In 2 Days _____ In 1 Week _____ Other _____

Additional Comments: ____

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