

# HILLS ENT

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: \_\_\_\_\_ 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: \_\_\_\_\_