3150 E. 3rd Ave. Suite 300
Denver, CO. 80206
info@denversinusare.com
P: 720-899-9489
F: 720-953-5151

DENVER SINUS CARE

WESTERN SINUS & SKULL BASE CONSULTANTS

Edward Hepworth, MD
Alison Love, NP
Sarah Reynolds, NP

REFERRAL FORM

Thank you for choosing to refer your patient to Denver Sinus Care/Western Sinus & Skull Base Consultants. To start the referral process, please complete this form and fax it to our office.

- Send brief, pertinent medical records, including test results and imaging, that support the consultation request
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required

Date _____ From _____

No. of pages _____ Title _____

To **DSC/WSSBC** Phone _____

Fax **720-953-5151** Fax _____

PATIENT INFORMATION

Name of patient _____ D.O.B. _____

Cell Phone _____ Home Phone _____

Parent or caregiver (if applicable) _____

Address _____

City _____ State _____ Zip _____

Insurance (Please attach front/back of card) _____

CONSULTATION REQUEST DETAILS

Diagnosis/ICD-10 _____ Notes Attached Yes ◯ No ◯

Reason for Consultation _____

Imaging Performed (Type/Location) _____

By providing the information requested and signing below, you agree that you have received patient authorization to release Information to us, and that following consultation, we may initiate treatment or perform medically necessary diagnostics.
We look forward to collaborating with you on your patient's care.

REFERRING PHYSICIAN INFORMATION

Referring MD _____ Specialty _____

Phone _____ Fax _____

Primary care provider (if different) _____ Phone _____

Signature _____

Updated 4/2026