

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	

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.