ENT ASSOCIATES
OF FRESNO

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ENTFresno.com

Referral Form

Date: _____ Number of Pages: _____

( )First Available ( ) Dr. Jennifer Davies ( ) Dr. George Hsu

( ) Dr. John Kerr ( ) Dr. David Hicks

Patient Name: _____ Email Address: _____

Mailing Address: _____

DOB: _____ Home Phone: _____ Cell Phone: _____

Diagnosis (REQUIRED): _____

Referring Physician: _____

Phone: _____ Fax: _____

PCP (if different from referring): _____

Insurance: _____

Secondary Insurance: _____

REQUIRED PATIENT INFORMATION

- ☐ Copy of referral
  *Must include HMO referral for appointment to be scheduled
- ☐ Copy of patient insurance card and demographics
- ☐ Copy of last visit
- ☐ Copy of recent imaging (CT, MRI, Xray) related to diagnosis – *SEE BELOW*

PATIENT MUST HAND CARRY THE FILMS OR DISCS OF THEIR IMAGING (CT, MRI, XRAY) IF NOT, THE PATIENT WILL BE RESCHEDULED

REFERRING PROVIDER MUST NOTIFY PATIENTS OF IMAGING INSTRUCTIONS

Thank you very much for referring your patient to our office!
NOTE: ALL INFORMATION IS NEEDED TO SCHEDULE AN APPOINTMENT