



Duke Surgery

DUKE UNIVERSITY MEDICAL CENTER

Division of Otolaryngology—Head and Neck Surgery

CONFIDENTIAL FAX

To _____

Duke University Medical Center

Fax 919-668-6036

DUMC 3805

Durham, NC 27710

From _____

Tel: 919-668-6065

Fax: 919-668-6036

Date _____

Patient name _____

www.dukeent.org

CONFIDENTIAL

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PATIENT REFERRAL FORM

- I verify that I have spoken with the patient and he or she has agreed that the Division of Otolaryngology—Head and Neck Surgery may contact him or her for an appointment.

Referring physician _____

Office telephone _____ Office fax _____

Patient's name _____
Last First M.I.

Patient's phone (Home or Cell) _____ (Work) _____

Insurance authorization # (if applicable) _____

REFERRAL REQUESTS

- I request that your office contact my patient and schedule an appointment and relevant studies.
- I would like a physician to contact me before contacting my patient.
- This patient has already been scheduled through the clinic.

BRIEF RELEVANT PATIENT CLINICAL INFORMATION
