

Patient Referral Form

2910 N. Patterson Street, Valdosta, GA 31602

Phone: (229) 244-2562 Fax: (229) 249-0000 Audiology: (229) 242-1111

Date: _____



*****Please complete the patient referral form and provide all detailed medical records pertinent to Otolaryngology BEFORE the patient is seen by our physicians.**

****Last office notes **MRI, CT, X-ray, Audio **Lab results (last 3 months) **Patient EMR Demographics/Insurance info**

Please select preferred Physician: First Available

Dr. Ronald Allen

Dr. Theodore Kanne

Dr. Thomas Phillips

Audiology/Dr. Carroll

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

DOB: ____/____/____ SS# ____ - ____ - ____ Gender: __M__F__

Address: _____ City, ST, Zip _____

Email Address for Patient Portal: _____

Primary Phone # ____ - ____ - ____ Work# ____ - ____ - ____ Cell Phone # ____ - ____ - ____

Insurance Plan: _____ ID# _____

Emergency/Parent Contact: _____

****IMPORTANT:** If patient has Tricare, an authorization must be received before an appointment can be scheduled.

REFERRING PHYSICIAN INFORMATION

Physician: _____

Address: (if new referring physician) _____ Phone: _____

Fax: ____ - ____ - ____ Referring contact person: _____ Phone ext#: _____

Reason for Referral: _____

****Note**** Please communicate the importance of bringing their *insurance card, ID, medication list*, and be prepared to pay co-pay, co-insurance or deductible at "time of service".

We will fax the scheduled date/time back to you. Please contact your patient of the upcoming appointment. If they Cancel or No show, we will provide you this information after the appointment date.

Missed Appointments will be charged **\$35.00 fee**.

It is our intent to provide your patient with the first available appointment. Please provide us with 2-3 business days to get appointment information returned to you. If you do not receive information, please call our office.

ENT & Allergy Associates of South Georgia

We thank you for your referral!!

Revised 08/28/2020