HILLS E·N·T
INSTITUTE

David P. Schleimer, D.O.

Physician Referral Request

Thank you for choosing to refer your patient to us. To start the referral process, please complete this form and fax it to our office.

REFERRAL FAX: (248) 268-0179

Referring Provider Information

Referred by Dr. _____ Medical Group: _____

Telephone: _____ Fax: _____ PCP: _____

Address: _____ City: _____ State: _____ Zip: _____

This form was completed by: _____ Date: _____

Patient Information

Patient Name: _____ Birthdate: _____ Sex: __M __F

Address: _____ City: _____ State: _____ Zip: _____

Patient Telephone: _____ Patient Cell Phone: _____

Reason for Referral

Diagnosis: _____

Type of service requested: *(select one)*

Evaluation ____ Treatment _____ 2nd Opinion _____

Patient needs to be seen: *(select one)*

Immediately _____ In 2 Days _____ In 1 Week _____ Other _____

Additional Comments: _____

_____

_____