Willamette ENT
Ear • Nose • Throat

PATIENT REFERRAL REQUEST

ONLY USE IF CANNOT SEND BY DIRECT MESSAGE

Patient Information

Last Name:______________________________ First Name:____________________ MI: ____

Mailing Address: ____

Home Phone:______________________ Cell Phone: ____________________

DOB:________ Email: _______________________ Parent/Guardian:____________________

Insurance Information

Primary Insurance:___________________________ ID:______________________

Secondary Insurance:_________________________ ID:______________________

Prior Authorization / Referral #: ________________________________ # of Visits: _________

Reason for Referral

☐ Hearing loss ☐ Ear Complaints ☐ Nasal Issues / Allergies

☐ Vertigo ☐ Thyroid / Neck Mass ☐ Throat Complaints

☐ Other: _________________________

☐ ASAP – mark only for urgent issues to be seen within 72 hours

Please fax this form along with chart notes, demographics, diagnostic tests, and copy of insurance referral to: (503) 399-1229. Patient may contact us directly to schedule after one week.

Referring Provider: ______________________________

Facility: ____

Thank you for your referral!

We strive to help your patients breathe better, hear better, feel better and look better!

3099 River Road South, Suite 150 • Salem, Oregon 97302
PHONE: 503-581-1567 FAX: 503-399-1229 BILLING: 503-581-9445
ENTsalem.com