BEACH CITIES ENTS
EAR NOSE THROAT SURGEONS

ENT Referral Form

Phone Number (310) 540-2111 **Fax Number (310) 944-9295**

Patient Information

Patient Name: _____ DOB: _____

Patient Contact Information: _____
If Patient is a Child, Parent/Guardian Name(s) _____

Primary Insurance:_____ Policy # _____ Grp #_____

Secondary Insurance: _____ Policy # _____ Grp # _____

Referral Required by Insurance Co: Y / N
Authorization Number: _____
(please attach copy of authorization, if required)

Referral Information

Diagnosis/Reason for Consultation: _____

_____

Any studies performed related to this medical problem?
(please attach copies of the reports or list location, name and date of study)

Audiometric Testing Ordered: Y / N

Urgency: (circle one) **Emergency** **Within 1 week** **Next Available**

Provider Preferred: (circle one) **No Preference** **Kemi Ajibola, PA-C**

Brett Levine, MD **Maher Sesi, MD** **Benjamin Rafii, MD** **Ashley Dao, MD**

Referring Doctor/Dentist: _____

Referring Doctor/Dentist Contact and Phone Number: _____

Additional Comments: _____

_____

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