HAYSMED

HaysMed Ear, Nose, and Throat

Request for Consultation, New Patient, or Self Referral

2214 Canterbury Drive, Suite 304 | Hays, KS 67601 | 785.650.2880 | FAX 785.650.2899

❑ *Consultation* ❑ *New Patient/Self Referral*

Patient Name:_____ Date:_____

DOB:_____ SSN:_____

Phone Numbers Home:_____ Cell:_____ Work:_____

Address: _____

City State Zip Code

Requesting Physician:_____

Physician's Address:_____

City State Zip Code

Phone:_____ Fax:_____

Requested Physician:_____ or ❑ First Available

Reason for Consultation:

_____

_____

Has imaging been performed? _____

Does the referral include any ear conditions or concerns? _____

Is the patient a veteran? ❑ Yes ❑ No If yes, has a Request of Service (ROS) been sent? ❑ Yes ❑ No

Appointment Date:_____ Time:_____

Clinics: Please fax the following information with the completed form.

- ❑ Demographics
- ❑ History & Physical (past 1-2 years)
- ❑ Current and Complete Medication List
- ❑ Lab Reports (past 1-2 years)
- ❑ Imaging Reports (past 1-2 years)
- ❑ Pathology Reports (past 1-2 years)

_____ _____

Signature of Person Completing Form Date/Time

DOB: D A/Sdt: