DR JASON CHAU GENERAL ENT REFERRAL FORM

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☐ M ☐ F ☐ X

LAST Name: ____________________ **FIRST Name:** ____________________

DATE OF BIRTH:____________ **AGE:** _____ **PHONE #:** ____________________

FULL ADDRESS: (include city & postal code) ________________________________

PHN: ____________________ **E-MAIL** ____________________
(or patient label) **If any of the above fields are missing, the referral will not be processed**

REFERRAL INFORMATION:

REASON FOR REFERRAL:

- ☐ **Head and Neck Mass** (accompanied with relevant testing and work-up)
- ☐ **Oral Lesion** ____________________
- ☐ **Sinusitis** (CT Sinuses included)
- ☐ **Deviated Nasal Septum**
- ☐ **Nasal congestion**
- ☐ **Recurrent Acute Tonsillitis / Tonsillar Abscess**
- ☐ **Recurrent ear infections**
- ☐ **Hearing loss** (audiogram included)
- ☐ **Other General ENT Question:** ____________________

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CURRENT INVESTIGATIONS / TREATMENT TRIALED : ☐ Medical history attached on next page

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REFERRING PHYSICIAN INFORMATION **Referral Date:** ____________________

Print Name:	Signature:
Physician Phone:	Physician Fax:
Physician Prac ID:	Physician Address:

Family Doctor (if different than referring): ____________________