Patient Referral Request

Referral Coordinators:

Thank you for entrusting us with the care of your patients! Complete Sections 1 and 2 below. Then fax, along with medical records and authorization information, to 704-752-7576. We will schedule the appointment and fax the information back to you for your records.

1. Referring Provider Information:

Referring Practice: ______________________________ Date: ____________________

Referring Physician: ____

Phone: ________________________ Fax: ________________________

2. Patient Information:

Patient's Name: __________________________________ Date of Birth: _____________

Insurance: _______________________________ Insurance ID#: ___________________

Parent's Name (first and last) if patient is a chld: ___________________________________

Preferred Phone numbers: Home: _____________________ Cell: ___________________

Diagnosis/Complaint: ____

Should we perform a hearing test as part of our initial evaluation? Yes / No

Should we test the patient for respiratory allergies at the initial evaluation? Yes / No

Preferred Office Location: ___ Monroe ___ Charlotte (Arboretum) ___ First Available

Preferred Physician: ___ First Available ___ William McClelland, MD ___ Jeffrey Brink, MD

___ Daniel Gerry, MD ___ Karen Greene, PA

**Will an interpreter be needed? Yes / No **Language: ____________________

Please have your patients visit our website at www.CornerStoneENT.com
to request an invitation to our patient portal.

*****************Section below for use by CornerStone Ear, Nose & Throat *****************

Appointment Scheduled: Patient ID: _____________________ ID#: _________________

Physician: _______________________ Date: _____________________ Time: _________

Audiology: _______________________ Date: _____________________ Time: _________

Charlotte (Arboretum) ___ Monroe ___

tel | 704.752.7575
fax | 704.752.7576
web | www.CornerStoneENT.com

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Charlotte, NC 28277

Monroe
1107 Reynolds Street
Monroe, NC 28112