SouthEastern
Ear Nose & Throat
ALLERGY & SLEEP DISORDERS

CONSULTATION REQUEST

PATIENT INFORMATION

Name of Patient: _____ **Date of Birth:** _____

Name of Parent: _____

Address: _____

Home Phone: _____ **Work/Mobile Phone:** _____

Insurance Type: _____ **ID #:** _____

Referral Required: _____ **Auth #:** _____

CONSULTATION REQUESTED

Patient needs to be seen: *Immediately* *1 week* *2 week* *1st Available*
(Circle one)

Patient is being referred for: *Evaluation* *Treatment* *2nd Opinion* *Audio Only*
(Circle one)

Additional Comments:

Please evaluate/treat for: _____ **Diagnosis:** _____

Please communicate with our practice via: *Fax* *Mail* *Phone*
(Circle one)

PLEASE FAX ALL CONSULTATION REQUESTS TO US AT (803) 509-7213

Referred by (Doctor Name): _____ **Phone:** _____

Staff person making referral: _____ **Date:** _____ **Fax:** _____

If an urgent consultation is necessary, please contact our office at (803) 509-7200 to speak directly to our staff.

Patient appointment has been scheduled for: **Date:** _____ **Time:** _____

SOUTHEASTERN EAR, NOSE, THROAT, ALLERGY & SLEEP DISORDERS INSTITUTE
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