NORTH ENT
OTOLARYNGOLOGY

8760 Jane St #103, Vaughan, ON L4K 0E8
P: 905.695.2505 info@northentclinic.com
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NORTH ENT CLINIC REFERRAL FORM

North ENT Clinic is committed to providing comprehensive ENT care and an exceptional patient experience, with minimal waiting time. Thank you for the opportunity to participate in the care of your patient. *Sincerely, Dr. Aviva Fliker.*

PATIENT INFORMATION

Name: _____
Last First

Date of Birth: _____ _____ ☐ Male ☐ Female

Address: _____
Street# Street Name City Province Postal Code

Phone: _____ Email: _____

OHIP #: _____

REASON FOR REFERRAL

Urgent

- ○ Head & Neck Lesion or Mass
- ○ Sudden Sensory Neural Hearing Loss
- ○ FB Ear or Nose (child)
- ○ Hemoptysis
- ○ Stridor/Dyspnea

Other:

- ○ _____
- ○ _____

Semi-Urgent

- ○ Epistaxis
- ○ Thyroid Nodule
- ○ Chronic Cough
- ○ Dysphagia
- ○ Dysphonia
- ○ Recurrent Otitis Media/Chronic
- ○ Otitis Media w/ Effusion
- ○ Tympanic Membrane Perforation
- ○ Recurrent/Chronic Sinusitis

Elective

- ○ Nasal Obstruction/ congestion
- ○ Longer Standing Hearing Loss
- ○ Chronic Tonsilitis Adult
- ○ Asymmetric Hearing Loss
- ○ Vertigo
- ○ Dry Mouth / Xerostomia
- ○ Sleep Disordered Breathing
- ○ Cerumen Impaction
- ○ Recurrent Tonsilitis

REFERRING PHYSICIAN INFORMATION

Name: _____ Billing #: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

THANK YOU FOR YOUR REFERRAL

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