NORTH ENT
OTOLARYNGOLOGY

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, North ENT.

PATIENT INFORMATION

Name: _____ _____
LAST FIRST

Date of Birth: _____

Address: _____

Phone: _____ OHIP #: _____

Email: _____

PATIENT REQUIRES AUDIOGRAM O Yes O No

REASON FOR REFERRAL

URGENT

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

OTHER: _____

_____

_____

SEMI-URGENT

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

ELECTIVE

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

REFERRING PHYSICIAN INFORMATION

Name: _____ Billing #: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

THANK YOU FOR YOUR REFERRAL

NORTH ENT
OTOLARYNGOLOGY

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