Appointment Information

LSU MR #_____
Patient Notified: _____

Date: _____
Time: _____

Referral to (if specific request): Dr. _____
Department of Otolaryngology / Head & Neck Surgery / Head & Neck Cancer / Pediatric ENT / Otology
Phone: 318-675-6262
FAX TO: 318-675-6260

_____ _____ _____
Patient Name Date of Birth Sex

_____ _____
Street Address Social Security Number

_____ _____ _____
City, State, Zip Code Best Contact Phone Alternate Phone/Person

Insurance Information:

Company	Policy Holder	Policy Number	Effective Date	Phone #

*Please obtain any referrals needed and verify that University Health Shreveport is a participating provider.

Referral Information:

Referring physician: _____ PCP (if different): _____

Full Address: _____

Phone: _____ Fax: _____

Chief Complaint/ Diagnosis:

_____

** If imaging has been done it is IMPORTANT that we receive the imaging DISK **

Diagnostic Workup Completed	YES	NO
Tissue Biopsy (Pathology)		
Cytology		
Exploratory Surgery (Panendoscopy)		
CT Scan Neck w/contrast		
MRI Neck		
PET Scan		
Other Radiology		
Other Nuclear Medicine Studies		
Lab		
Cardio/Pulmonary/Neuro Surgical Risk Assessment (if applicable0		

Please Fax:

- **Copy of Insurance Cards**
- History & Physical
- Primary Care Provider (Most Recent H &P)
- Previous Treatment Records
- Operative Notes
- Radiology Reports (send images with patient)
- Pathology Report
- Lab Reports
- List of Medications