INSPIRE
ENT & PULMONOLOGY

REFERRAL REQUEST

Date _____

Patient Name _____ DOB _____ Male/Female

Contact Name (Ex: parent/spouse) _____ Phone Number _____

Insurance Company _____

Reason for Consult _____

Appointment Needed: ☐ Routine *(Guaranteed appointment within two weeks)* ☐ Urgent *(Guaranteed appointment within one week)*

**Please select the services requested*

Physician Referral		Other Services *(No physician appointment required)*	
☐	***ENT***	☐	***Allergy Testing***
		☐	***Hearing Test/Hearing Aid Services***
☐	***Pulmonology***	☐	***Complete Pulmonary Function Test***
		☐	***PH Probe***

Referring Physician _____

Office Phone _____ Office Contact (if needed) _____

Please include the following information:
☐ Demographics ☐ Medication List
☐ Pertinent office notes, labs, X-rays and other test results

Please fax this form to our dedicated referral line.

785.320.2835

Your patients will be contacted within **24 hours** of receipt of this referral sheet to schedule an appointment with one of our providers.

For office use only:

Patient Scheduled _____ Scheduled by _____ Unable to Reach _____