

**Please fax to 617-638-6424**



Appointment
Date: _____
Time: _____
Provider: _____

**Department of Otolaryngology- Head and Neck Surgery**

Audiology  
Center for Voice and Swallowing Disorders  
Facial Plastics and Reconstructive Surgery

**Referral Form**

**Patient Information:**

Name: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Medical Concern / Reason for Referral: \_\_\_\_\_

**Patient Insurance / Billing Information:**

Carrier: \_\_\_\_\_

Authorization Number / Referral: \_\_\_\_\_

Approval start date and end date: \_\_\_\_\_

**Referring Physician Information:**

Name: \_\_\_\_\_ \* Phone Number: \_\_\_\_\_

Contact person (name and number): \_\_\_\_\_

\* Fax Number: \_\_\_\_\_

*Please contact Sheryl Debarros with any questions at 617-414-2307  
Or  
Peggy Belmonte, Operations Office Manager, at 617-414-6730*