Consultation Request

Patient Name:	DOB:
Address:	
Home Number:	Work Number:

Insurance:

Parent Name:

For: Evaluation Treatment 2nd opinion other

Comments: Please evaluate and treat for: Referring Doctor: **Individual NPI #:** **(Medicaid)** Number of visits: *****Please call to schedule the appointment** then fax medical records, MRI, CT, xray reports with this Form to 919-776-3834.

Please communicate via: Fax Mail Phone

Central Carolina ENT Associates	Dr. Doris Lin
1001 W. Williams St, Ste 103	Dr. Richard Alexander
Apex NC 27502	Beth Lisi, PA-C
Ph: 919-363-9311	Fax: 919-776-3834