

Patient Label

**ENT: Airway, Throat, Neck, and Voice**

Fax 504.903.3479

From:    BMC    EKL    LJC    LAK    ILH    UMC    WOM    Other: \_\_\_\_\_

Attending Provider: \_\_\_\_\_ ID Number: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical Record Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

1° Contact Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ 2° Contact Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Indicate Reason for Referral and note needed workup:**

- 519.8 Airway Obstruction or Stridor
- 786.2 Chronic Cough
- 787.2 Dysphagia
- 528.3 Fistula
- 784.49 Hoarseness
- 785.6 Lymphadenopathy (including Chronic Adenoid Hypertrophy) **(1)**
- 780.57 Obstructive Sleep Apnea or Snoring **(2)**
- 527.2 Salivary Disorders: Inflammation and/or Stones **(3)**
- 474.00 Tonsillitis **(4)**
- 478.30 Vocal Cord Paralysis
- Other: ICD: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

**(1)** CBC, HIV test, Monospot, EBV titers, CXR, FNA lymph node (if available). Consider empiric course abx.

**(2)** Refer for outpatient overnight polysomnography (sleep study). See Sleep Lab Referral Form

**(3)** Treat before referral with antistaphylococcal antibiotics, sialagogues (lemon drops, sour candy, etc.), NSAIDs, and warm compresses to inflamed gland.

**(4)** Indications for ENT referral: >6 episodes/yr, ≥5 episodes/2+ yrs, or ≥4 episodes/3+ yrs, ≥2 cases of peritonsillar abscess. Treat acute tonsillitis empirically with pen VK, amoxicillin, or clindamycin.

**Have the patient bring copies of any lab work, studies, and medical records not available at ILH.**

**Clinical History Relevant to this Referral:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact No.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Referring Service/Clinic: \_\_\_\_\_

Fax No.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

**OFFICE USE ONLY:** Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_:\_\_ am/pm.

If not scheduled, Indicate Reason & Recommendation: \_\_\_\_\_

Reviewing Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Rev 08/05/09