



Otolaryngology/Head & Neck Surgery Referral Form

3100 N Wellness Dr. Holland, MI 49424 Ph:(616) 994-2770 Fax:(616) 920-6533	1445 Sheldon Rd Suite 303 Grand Haven, MI 49417 Ph: (616) 414-3088 Fax:(616) 920-6533	3501 Rivertown Point Ct. SW Grandville, MI 49418 Ph: (616) 994-2770 Fax:(616) 920-6533	205 Broadway South Haven, MI 49090 Ph:(269) 244-3421 Fax:(616) 920-6533	230 West Oak St. Fremont, MI 49412 Ph:(616) 994-2770 Fax:(616) 920-6533	516 Linn St Allegan, MI 49010 ph: (616) 994-2770 Fax: (616) 920-6533
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Dr. Richard J. Strabbing, DO, FAOCO
Dr. Seth Palmer, DO, FAOCO
Dr. Jason Stubbs, DO, FAOCO
Dr. Devin Mistry, DO, FAOCO
Dr. Michael Foster, DO, FAOCO

Aleica Kovatch, PA-C
Stefan Kuipers, PA-C
Alyssa Miller, PA-C
Scott Parrott, PA-C

Dr. Erica Mandrick, AuD
Dr. Stacey Braund, AuD
Dr. Lindsay Churches, AuD
Dr. Elizabeth Hughes

Name: _____ Sex: _____

Address: _____

Birthdate: _____ Parent/Guardian: _____

Home Phone: _____ Cell: _____

Insurance: _____ SS#: _____

Policy#/Policy Holder: _____

Reason for Referral/Diagnosis: _____

Person filling out form: _____

Please include the following information that pertains to the condition of the referral when faxing the form to us:

Progress Notes

- Medication(s)
- Any X-Ray, CT scans, MRI, Bone Scan related to area being evaluated
- Growth chart (pediatric patient)

After all records have been received, we will contact the patient and set an appointment. We will send an information packet to the patient which includes a map to our office.

Referring Doctor: _____

Referring Address: _____

Referring Phone: _____ Referring Fax: _____