ANDROS ENT
EAR NOSE THROAT & SLEEP CENTER
My Kind of Care

Inell C. Rosario, MD
Diplomate American Academy of Otolaryngology Head and Neck Surgery
Board Certified in Sleep Medicine

Cornelia Dahm, MD
Board Certified in Sleep Medicine
Board Certified in Pulmonology

Alexander P. Coyne, PA-C, MPAS
Board Certified with NCCPA

5565 Blaine Ave
Suite 225 & Suite 275
Inver Grove Heights, MN 55076
Clinic: 651-888-7800
Fax: 651-888-7801

REQUEST for CONSULT/REFERRAL FORM

Name:_____ DOB:_____ SSN:_____
(last 4 Digits)

Address_____

Male / Female …*if child*, Parent/Guardian:_____ Preferred phone: _____

Primary Insurance Name:_____ Policy #_____ Group # _____

Secondary Insurance Name:_____ Policy #_____ Group # _____

DIAGNOSIS/REASON FOR VISIT: _____
Must be included to schedule appointment.

Additional Comments/Info: _____

☐ **AUDIOMETRIC Testing ordered.** *(hearing testing)*

Date of Symptom Onset: _____ ☐**Acute** ❒ **Chronic** x_____❒ month(s) ❒ week(s)

Referring Facility: _____ Office Phone: _____

Referring Physician: _____ Office Fax: _____

Please fax all information relevant to your patient's visit with us. **Fax 651-888-7801**

Date_____Time_____Provider Signature:_____

****If EMERGENT appointment is required, call 651-888-7800.****

❒ **URGENT appointment requested (within 10 days)** ❒ **NEXT AVAILABLE appointment requested**

ENT & Audiology Use Only:
Appointment Date:_____ Time: _____
Provider(s):_____ **ENT Staff to Return to Ref Provider via FAX.**