



My Kind of Care

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

Kaveh Karimnejad, MD
Board Certified in Otolaryngology Head and
Neck Surgery
Fellow in Plastic Surgery

Angela Messer, PA-C, MPAS Board Certified
with NCCPA

Robyn Brown, 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

2780 Snelling Ave N
Suite 201
Roseville, MN 55113
Clinic: 651-888-7850
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.**