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| **Texas Sinus Institute Texas Skull Base Physicians** |
| **713-486-5000 (voice)** | **713-383-1410 (fax)** | [**www.ent4.me**](http://www.ent4.me/) |

**CONSULTATION REQUEST FORM**

Instructions: Please provide all available information and then fax the form back to us at 713-383-1410.

|  |  |  |
| --- | --- | --- |
| **Name** | **DOB** | **Date** |
| **Other contact/parent** | **UTP IDX#** | **MH MRN** |
| **Telephone** |
| H |  | W |  | M |  |  |
| **Insurance company (primary)** |
| ID# |  | Group # | Telephone |  | Fax |  |
| **Insurance company (secondary)** |
| ID# |  | Group # | Telephone |  | Fax |  |
| **Appointment** |
| * Appointment scheduled. (Please specify date.)
 | * Please call the patient to schedule the appointment.
 |
| **Surgeon** |  |  |  |  |  |  |
| * Martin J. Citardi, MD
 | * Amber Luong, MD, PhD
 | * William Yao, MD
 |
| **Specialty Area** |
|  | * Sinus
 |  | * Skull Base
 |  |
| **Patient History (Reason for Consult)** |
| **Imaging** |  |  |  |  |  |  |
| * Yes
* No
 | Details |  |  |  |  |  |
| **Requesting Physician** |
| Name |  |  |  | Date |  |
| **Address** |  |  |  |  |  |  |
| Street |  | City |  | State | Zip |
| **Telephone** | **Fax** |



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|  | **Location** |
| **Physicians**Martin J. Citardi, MD*Professor & Chair*Amber Luong, MD, PhD*Associate Professor*William Yao, MD*Assistant Professor* |  |
| 6400 Fannin StreetSuite 2700Houston, TX 77030713-486-5000 (v)713-383-1410 (f) |
| **Texas Sinus Institute**[www.texassinus.org](http://www.texassinus.org/) | **Texas Skull Base Physicians**[www.texasskullbase.org](http://www.texasskullbase.org/) |