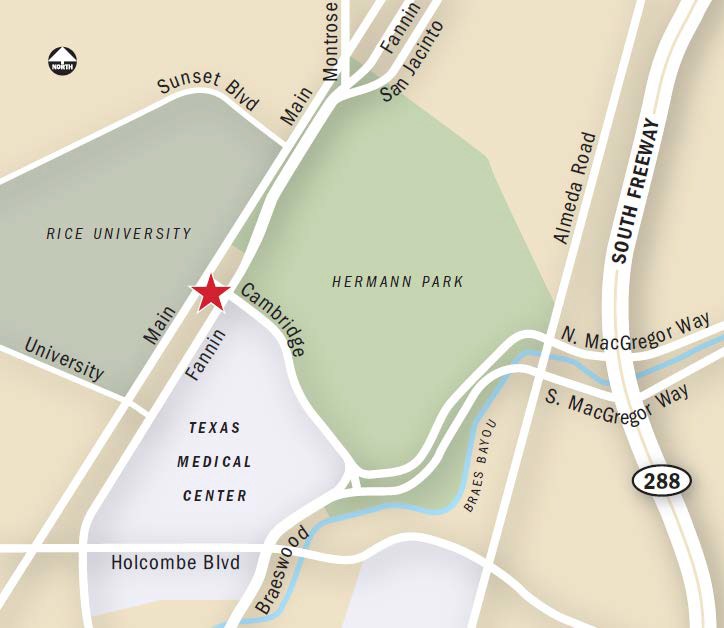
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| **Texas Sinus Institute Texas Skull Base Physicians** | | |
| **713-486-5000 (voice)** | **713-383-1410 (fax)** | [**www.ent4.me**](http://www.ent4.me/) |

**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 Street  Suite 2700  Houston, TX 77030  713-486-5000 (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/) |