Referral Request

*Thank you for choosing **Westside Head & Neck.***
We look forward to partnering with you in your patient's care.
Please fax form to: (310) 204-4474
or call us at (310) 204-4111

Date: _____ #pages:_____ ☐ Routine ☐ Urgent

REFERRING PROVIDER INFORMATION

Referred by (MD): _____

Medical Group: _____

Phone: _____ Fax: _____ PCP: _____

. . . . . .

PATIENT INFORMATION (Please provide copy of patient demographics/face sheet):

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Phone: _____ Gender: ☐ Male ☐ Female

Patient's Address: _____

City/State/Zip: _____

Language: _____ Needs Interpreter? Y / N

. . . . . .

REASON FOR REFERRAL

Reason for Referral:_____

Physician Requested: ☐ Dr. Amanda Salvado ☐ Dr. Michelle Putnam ☐ First Available
☐ Dr. Dorothy Wang ☐ Dr. Behrad Aynehchi

DOCUMENTATION REQUIRED (Please fax with this form):

- Recent / relevant typed clinical notes/test results, i.e. history & physical, MRI/CT/X-rays results
- Proof of insurance
- Authorization information (if required)

Westside Head & Neck
Culver City: 3831 Hughes Avenue, Suite 504 Culver City, CA 90232
Santa Monica: 1301 20th Street, Suite 510 Santa Monica, CA 90404
Tel: (310) 204–4111 Fax: (310) 204–4474