

Appointment Information

Patient Notified: _____

Date: _____

Time: _____



**Feist-Weiller
Cancer Center**

Referral to (if specific request): Dr. _____

Department of Otolaryngology/ Head & Neck Surgery & Oncology/ Pediatric ENT

Phone: 318-675-6262

FAX TO: 318-675-6260

Patient Name

Date of Birth

Sex

Street Address

Social Security Number

City, State, Zip Code

Best Contact Phone

Alternate Phone

Insurance Information:

Company	Policy Holder	Policy Number	Effective Date	Phone #

*Please obtain any referrals needed and verify that LSUHSC- Shreveport is a participating provider.

We are out of network for Humana Gold and without waiver are unable to see those pts at this time

Referral Information:

Referring physician: _____ PCP (if different): _____

Full Address: _____

Phone: _____ Fax: _____

Chief Complaint/ Diagnosis: _____

Diagnostic Workup Completed	YES	NO
Tissue Biopsy (Pathology)		
Cytology		
Exploratory Surgery (Panendoscopy)		
CT Scan Neck w/contrast		
MRI Neck		
PET Scan		
Other Radiology		
Other Nuclear Medicine Studies		
Lab		
Cardio/Pulmonary/Neuro Surgical Risk Assessment (if applicable)		

Please Fax:

- **Copy of Insurance Cards**
- History & Physical
- Primary Care Provider (Most Recent H &P)
- Previous Treatment Records
- Operative Notes
- Radiology Reports (send images with patient)
- Pathology Report
- Lab Reports
- List of Medications