

DAVIDWITSELLMD.COM

Duke Department of Surgery | Division of Otolaryngology—Head and Neck Surgery

PATIENT REFERRAL FORM

- I verify that I have spoken with the patient and they have agreed for the office of David L. Witsell, MD to contact them for an appointment.

Referring Physician _____

Office Telephone _____ Office Fax _____

Patient's name _____
Last First M.I.

Patient's phone (H or Cell) _____ (W) _____

Insurance authorization # (if applicable) _____

REFERRAL REQUESTS

- I request that your office contact my patient and schedule an appointment and relevant studies.
- I would like Dr. Witsell to contact me before contacting my patient.
- This patient has already been scheduled through the clinic.

BRIEF RELEVANT PATIENT CLINICAL INFORMATION
