MARKHAM EAR, NOSE AND THROAT CLINIC

www.MarkhamENT.com

❑ Dr. Bosco Lui ❑ Dr. Joanne Kim ❑ First Available

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Referral Form

Patient Information

Name _____ ☐ M ☐ F

HCN _____ DOB _____

Address _____

Telephone _____ eMail _____

***Appointment information will be sent via automated messaging system. Please make sure cell phone no. is correct.*

Reason for Referral

Ear

- ☐ Hearing Loss / Bilateral tinnitus
  - ☐ Hearing Test ONLY
  - ☐ Hearing Test and Consultation
- ☐ Dizziness / Vertigo
- ☐ Ear Infection / pain
- ☐ Unilateral tinnitus
- ☐ Bone Conduction Hearing Aids Implant
- ☐ Pediatric Ear Infection / Hearing Loss
- ☐ Others _____

Nose

- ☐ Epistaxis
- ☐ NPC Screening with Family History
- ☐ Nasal obstruction
- ☐ Nasal polyps
- ☐ Post nasal drip
- ☐ Sinusitis
- ☐ Deviated Nasal Septum
- ☐ Others _____

Throat

- ☐ Adenotonsillar Hypertrophy
- ☐ Globus sensation
- ☐ Throat Irritation
- ☐ Tonsillitis / Tonsil stones
- ☐ Snoring / OSA
- ☐ Others _____

Neck

- ☐ Neck Mass
- ☐ Parotid Mass
- ☐ Thyroid Nodule(s)
- ☐ Others _____

FNA *(please attach thyroid U/S report, current list of medications and recent TSH blood test report)

- ☐ Ultrasound Guided FNA ONLY
- ☐ Ultrasound Guided FNA and Consultation

Clinical Information

Referring Physician

Name _____ MD Signature _____

Telephone _____ Billing No. _____

Fax _____ Date _____