

Masdon  
ENT &  
Facial  
Plastic Surgery  
Masdon ENT Hearing Aids

**DR. JAMES L. MASDON, M.D. / DR. HANNAH NIXON, A.U.D.**

Please complete this form and fax to us along with patient's records. We will call the patient to set up an appointment and we will fax this form back to you with the appointment date and time for your records.

**Fax - (256) 840-4584**

**REFERRAL FORM**

Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ NPI Number: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_

Does insurance require a referral? Yes No Referral Authorization Number: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PLEASE ATTACH:**

- REFERRAL IF REQUIRED BY INSURANCE
- MOST RECENT OFFICE VISIT AND ANY RELEVANT TESTING PERTAINING TO THEIR DIAGNOSIS.

**APPOINTMENT DATE & TIME:** \_\_\_\_\_

Thank you for your referral.

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