WakeMed

Ear, Nose & Throat – Head & Neck Surgery

WakeMed Raleigh Campus
3024 New Bern Avenue
Suite 200
Raleigh, NC 27610
Phone: 919-350-EARS (3277)
Fax: 919-350-9803

PROVIDERS: (Please check if referring to a specific provider.)

☐ Michael Ferguson, MD
☐ Allen Marshall, MD
☐ Stuart Ginn, MD
☐ Nathan Calloway, MD
☐ Gitanjali Fleischman, MD
☐ Lewis Overton, MD
☐ Next available appointment

WakeMed Oberlin
505 Oberlin Road
Suite 240
Raleigh, NC 27605
Phone: 919-350-EARS (3277)
Fax: 919-235-1379

PROVIDERS: (Please check if referring to a specific provider.)

☐ Michael Ferguson, MD
☐ Allen Marshall, MD
☐ Stuart Ginn, MD
☐ Nathan Calloway, MD
☐ Gitanjali Fleischman, MD
☐ Lewis Overton, MD
☐ Next available appointment

WakeMed North
Physicians Office Pavilion
10010 Falls of Neuse Road
Suite 305
Raleigh, NC 27614
Phone: 919-350-EARS (3277)
Fax: 919-350-9812

PROVIDERS: (Please check if referring to a specific provider.)

☐ Michael Ferguson, MD
☐ Allen Marshall, MD
☐ Next available appointment

WakeMed Apex Healthplex
120 Healthplex Way
Suite 302
Apex, NC 27502
Phone: 919-350-EARS (3277)
Fax: 919-235-6592

PROVIDERS: (Please check if referring to a specific provider.)

☐ Gitanjali Fleischman, MD
☐ Lewis Overton, MD
☐ Next available appointment

WakeMed Garner Healthplex
400 U.S. Highway 70 East
Suite 202
Garner, NC 27529
Phone: 919-350-EARS (3277)
Fax: 919-350-9813

PROVIDERS: (Please check if referring to a specific provider.)

☐ Allen Marshall, MD
☐ Stuart Ginn, MD
☐ Nathan Calloway, MD
☐ Next available appointment

REQUEST FOR CONSULTATION

PATIENT DEMOGRAPHIC INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F Race: _____

Address: _____ City/State/Zip: _____

Phone *(Please circle preferred number)* Home: _____ Cell: _____ Work: _____

Email: _____

Does patient/family need an interpreter? ☐ No ☐ Yes If yes, please specify language _____

INSURANCE INFORMATION

Insurance Name: _____

Policyholder's Name: _____ Policyholder's Date of Birth: _____

Insurance Phone: _____ Policy Number: _____ Group Number: _____

Medicaid Authorization NPI: _____ Authorized Number of Visits: _____

REFERRAL INFORMATION ☐ Routine ☐ Urgent

Reason for Referral: _____

_____

REFERRING PHYSICIAN INFORMATION

Name: _____

Practice Name (if applicable): _____

Address: _____

City/State/Zip: _____

Office Phone: _____ Fax: _____

Name of Person completing this form: _____

Please include with referral (all that are applicable)

☐ History/Office Notes

☐ Labs

☐ Imaging Studies (patient should bring films or CD)

☐ Other pertinent medical records

Thank you for referring your patient to WakeMed - Ear, Nose & Throat-Head & Neck Surgery