

## Consultation Request

Dear Dr. \_\_\_\_\_

Patient Name:	
Address:	
Home Number:	Work Number:

Insurance:
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Needs to be seen:	Immediately	2 days	1 week	other
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For:	Evaluation	Treatment	2 <sup>nd</sup> opinion	other
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Comments: Please evaluate and treat for _____
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Please communicate via:	Fax	Mail	Phone
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Central Carolina ENT Associates 1915 KM Wicker Dr Sanford NC 27330 Ph: 919-774-6829    Fax: 919-775-2327	Dr. William LeLiever Dr. Samuel Davis, III Dr. Doris Lin
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