OhioHealth Ear, Nose and Throat Physicians
Mykola "Dr. Myk" Prykhodko, MD
770 Balgreen Drive
Suite 209
Mansfield, Ohio 44906
Phone: (419) 756.5500
Fax: (419) 756.5502

PATIENT REFERRAL

Referring Physician: ____________________________ Phone: ________________
Fax #: ______________________ Date Faxed: ______________________________
PCP (if not referring): ____
Office Contact:____

Reason for Consult: ____
____

Has your patient had the following:

Audiology Testing
☐ Yes ☐ No When: ________ Where: ____________________

Radiology Test
☐ Yes ☐ No When: ________ Where: ____________________

Fax copies of any of the above records plus last 1-2 progress notes.

Patient name: ____
Address: ____
Phone: ____________________________ Date of Birth:____________________
SSN: ____
Insurance: ____

ENT Office Use Only
Appointment date and time: ____________________________

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