



Billings Clinic Ear Nose & Throat

1st Floor Ear Nose & Throat

801 N 29th Street

Billings, MT, 59101

Phone: 406-238-5048

Fax: 406-238-5043

Patient Name: _____ Date of Birth: _____ Patient Phone: _____

Reason for Consult: _____

Referring Provider: _____ Provider Phone: _____ Provider Fax: _____

Ear Nose & Throat REFERRAL REQUIREMENTS

Referral Letter

Face Sheet

Current Medication List

Recent relevant Progress Notes

Previous Otolaryngology records if patient has seen another provider besides Billings Clinic

All relevant imaging please push to Billings Clinic PACS

Pathology reports

Operative notes

Office visit notes

All Lab results within the last year

Radiology reports

Audiograms and any Audiology notes

Referring provider signature required: _____ Date: _____

****Please send referring provider notes, all ENT and Audiology medical records including images and demographics sheet.****

Date faxed: _____

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