



Consultation Request

Dear Dr. _____

Patient Name: _____

Address: _____

Home Number: _(_____)_____

Work Number: __ (_____)_____

Insurance: _____

Needs to be seen: *Immediately* *2 days* *1 week* *other*

For: *Evaluation* *Treatment* *2nd opinion* *other*

Comments:

Please evaluate and treat for _____

Please communicate via: *Fax* *Mail* *Phone*

Gulf Coast ENT & Allergy
5025 Deepwood Circle
Corpus Christi Texas, 78415
Office: 361-225-0839
Fax: 361-888-9126