



ALASKA FACIAL
PLASTIC SURGERY &
ENT

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P: (907) 600-0030
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New Patient Referral

Today's Date: ____/____/____

☐ URGENT

☐ NEXT AVAILABLE

Patient's Name: _____

DOB: ____/____/____ Patient's email: _____

Patient's contact number: _____

Patient's insurance (please list all)

Primary: _____ Member ID: _____

Secondary: _____ Member ID: _____

Tertiary: _____ Member ID: _____

Reason for Referral:

- ☐ Ear Problem
- ☐ Nose/Sinus
- ☐ Tonsils/Adenoids
- ☐ Thyroid

- ☐ Facial Lesion/Skin Cancer
- ☐ Cleft Lip/Palate
- ☐ Head and Neck Cancer
- ☐ Other: _____

Comments: _____

Provider Requesting Referral:

Name: _____ Signature: _____

Clinic Name: _____ Phone Number: _____

Along with our referral form, please include any relevant office visit notes, lab or imaging results, and patient demographic information. You may fax referrals and supporting documentation for review to (907) 206-7153 or email to patientinfo@afpent.hush.com.

To follow up on a referral, please call us at (907) 600-0030 and select the referral option!

Thank you so much for your kind referral! - AFPENT Team