SIERRA NEVADA
EAR • NOSE • THROAT

BALANCE THERAPY Referral Form

Fax Number: 775-883-0115 **Phone Number: 775-883-7666**

Patient Information

Patient Name: _____ DOB: _____

Primary Insurance: _____ Secondary Insurance: _____

Please list insurance company names, generic terms may result in an appointment delay.

Referral Required by Ins Co: Y / N

Who should we contact for the appointment? _____

Contact Phone: _____

Referral Information

Reason for Consultation: _____ Physical Therapy Treatment Only

_____ Dizziness Eval prior to Physical Therapy

Urgency: (please circle one) Next Available Other_____

Referring Doctor: _____

Referring Doctor Contact and Phone: _____

Comments: _____

_____

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