DR. CAMILLA STEPNIAK
OTOLARYNGOLOGY
HEAD & NECK SURGERY

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DR. KYLEN VAN OSCH
Otolaryngology - Head & Neck Surgery

We kindly ask that you visit our website (www.stepniakent.com) for information and guidance on common referral concerns prior to submitting a referral.

Referral to:(Select one)
⬜ First Available ⬜ Dr Stepniak ,Camilla ⬜ Dr Van Osch, Kylen
Date of referral: (MM/DD/YYYY) ____/____/____
Patient Name: _____ Sex: M__ F__
Health Card Number/Version Code: _____
DOB(MM/DD/YYYY): ____/____/_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email:_____
Address: _____ City: _____ Postal Code: _____

Detailed Reason For Referral:

Medical History: list any current or past medical conditions and major illnesses & year
(***The following does not need to be complete if a cumulative patient profile is attached)

Medical History: list any past surgeries including year

Medications: list all medications or attach a list:

Name of Medication	Dose(mg)	Frequency

Allergies: list any allergies or drug reactions

Referring Physician Name: _____
Address: _____
Physician Phone Number: _____ Fax: _____
Referring Physician Signature: _____
Referring Physician Billing Number: _____
Family physician (if Different from Referring Physician):_____

Updated Nov 2025