Pulmonary Referral Form

Location: Columbia ☐ Lexington ☐

I. Referring Type:

☐ New ☐ Established ☐ First available appointment

Patient/Physician preference: ____________________

II. Referral Information:

Reason for Referral: ____________________
Has the patient been evaluated by another pulmonologist in the past: Yes ____ No ____

If so the physicians name: ____________________

When was the patient seen: ____________________

Previous diagnostic testing: (check all that apply)

- ☐ Chest x-ray — Date: ____________
- ☐ Pulmonary Function test — Date: ____________
- ☐ CT scan - Area____________ — Date: ____________
- ☐ Office Notes — Date: ____________
- ☐ Sleep Study – Where ________ — Date: ____________

III. Referring Provider Information:

Physician Name: ____________________ Office Contact: ____________________

Office Telephone: ____________________ Office Fax: ____________________

IV. Patient Information:

Patient Name: ____________________ Date of Birth:____________________

SSN ____________________ Telephone: ____________________

INSURANCE REFERRAL NUMBER ____________________

PLEASE SEND DEMOGRAPHICS

Scheduling Information (office use only)

Appointment Date ____________ Time ________ Arrival Time ________

Spoke To ____________ Date ____________

Patient Notified Date: ____________ Mailed Patient Packet ☐

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