Request for Consultation

Pulmonology Referral Request

Patient Information

Patient Name: _____ Date of Birth:_____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance Company: _____ Alt Phone: _____

1. Is This an urgent pulmonary referral? ☐ No ☐ Yes

If yes, reason for urgency _____

2. Please describe the patient's chief complaint and include onset and frequency:

_____

_____

Please select diagnosis:	**Pre referral work up requirements by diagnosis:**
☐ **Asthma**	▶ Asthma; chest x-ray (report), Allergy testing, notes from other consultants
☐ **Apnea**	▶ Sleep apnea; chest x-ray (report), soft tissue neck x-ray, NICU notes and discharge summary notes from other consultants
☐ **BPD**	▶ O2 dependent, recurrent wheezing, hospitalizations; growth curve, neonatal discharge summary, chest x-ray (report)
☐ **General Pulmonary**	▶ Including but not limited to: chronic lung disease, chronic cough, recurrent pneumonia, abnormal chest x-ray, immunology disorders; chest x-ray (report), notes from other consultants

***These guidelines are to be used only as a tool for initial reference and not be used as exclusive indicators for referral to Pulmonology.**
***Patients should bring x-ray films to initial appointment**

To schedule an appointment, please provide the following by FAX at 901-287-6337:
☐ This completed form, patient demographics AND
☐ Medical records related to the chief complaint (Lab and test reports from the last year including respiratory cultures, pulmonary function and allergy testing/immune testing if applicable)

Referring Provider Name:_____Phone:_____ Fax:_____

Office Personnel Completing Form (if not MD):_____ Date:_____