

**NOTE: All areas of this form must be answered before appointment will be scheduled**

**Please type or print clearly**

**Requested Pulmonary/Sleep MD (if specific MD desired)** \_\_\_\_\_

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_, Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_ Phone number of Ins. Co. (\_\_\_\_) \_\_\_\_\_

ID Number and Name of Insured \_\_\_\_\_ HMO? \_\_\_\_\_

If so, Authorization # \_\_\_\_\_

**Please type or print clearly and check all that apply**

<b>Appointment Schedule:</b>	Urgent (within 2 weeks)		Next Available	
<b>Type of visit:</b>	Consultation	Second Opinion	Evaluate & Manage (transfer of care)	
<b>Primary Diagnosis:</b>	Alpha-1	Asthma	Bronchiectasis	Bronchitis
	COPD	CF	ILD/PF	LVRS
	LAM	Lung Cancer or Lung Mass/Nodule		Mediastinal Adenopathy/Mass
	NTM/TB	Pneumonitis	Pleural Disease/Effusion	PAH Sarcoidosis
	Sleep Disorders	SOB	Stent Placement	Tracheal/Bronchial Stenosis

**Other diagnosis not listed** \_\_\_\_\_

**Specific question to be addressed** \_\_\_\_\_

**Referring physician name & Specialty** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_, **Zip** \_\_\_\_\_

**Phone number** (\_\_\_\_) \_\_\_\_\_ **Fax** (\_\_\_\_) \_\_\_\_\_

**NPI** \_\_\_\_\_ **Taxonomy Code** \_\_\_\_\_

**Contact person** \_\_\_\_\_ **Phone number** (\_\_\_\_) \_\_\_\_\_

**PERTINENT STUDIES/PROCEDURES DONE-RECORDS MUST BE FAXED W/ THIS FORM**

**The films, slides and records should be given to the patient to bring with them to their appointment and/or faxed/fed-ex to our office before the patient will be seen.**