PATIENT REFERRAL FORM

Patient Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ Phone: _____

Reason for Patient Referral: _____

Service(s) Requested*

- ☐ Full Pulmonary Function Tests with Pre- and Post-Bronchodilator Spirometry, Lung Volumes, and Diffusion Test (DLCO)
- ☐ Pre- and Post-Bronchodilator Spirometry
- ☐ Spirometry without Bronchodilator
- ☐ Diffusion Test (DLCO)
- ☐ Lung Volumes
- ☐ 6-Minute Walk Study
- ☐ Methacholine Challenge Test

** Pulmonary tests may be done without seeing practitioner if written order on letterhead with diagnosis and medical necessity justification is forwarded with patient referral form.*

Referring Physician : _____ NPI:_____

Physician Signature: _____ Date: _____

Address: _____ Phone: _____ Fax: _____

Special Instructions:

_____

_____

Please fax referral form, patient demographics, and all pertinent clinical notes and records. If patient has had a recent chest X-ray or CT, please send films with patient.

THANK YOU FOR REFERRING YOUR PATIENT TO US!