CRITICAL CARE, PULMONARY & SLEEP
ASSOCIATES A PROFESSIONAL LLP

Physician Referral Form
Pulmonary or Sleep Medicine Office Visit

Patient Name_____ **Address**_____
Date of Birth_____ **Phone Number**_____
Diagnosis_____
Reason for Visit_____
Timeframe for Patient to Be Seen? _____
Requesting Physician_____ **Specialty**_____
Physician Phone Number_____ **Fax Number**_____
Insurance_____

Specialist Referral Required by Patient's Insurance?

- ☐ **Yes - Please Provide Referral for Services Requested**
- ☐ **No**

***Please Send Demographics and Insurance Information with the Following Information:**

- **Last 2 Office Visit Notes**
- **Recent Hospitalization Notes**
- **Testing Completed Within the Last 2 Years. <u>Please Send Reports and Discs for All Tests Selected Below</u>:**

☐ **CT Chest**
☐ **CXR**
☐ **Echo**
☐ **Labs**
☐ **Nocturnal Oximetry**

☐ **PET Scans**
☐ **PFT**
☐ **Sleep Study**
☐ **Stress Test**

☐ **Other Relevant Testing (please list):**
_____
_____
_____

Is Patient Currently on O2?

☐ **Yes @ _____ LPM**
☐ **24/7**
☐ **Nocturnal Only**
☐ **No**

Is Patient Currently on PAP Therapy?

☐ **Yes**
☐ **No**

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