Specialty Service Referral

Pulmonology Function Testing

Sarah Bush Lincoln

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PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4#_____

Address _____ City _____ State/Zip_____

Phone _____ County_____

Insurance Carrier Primary_____ Secondary _____

If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization #_____

Work Related ❑ Yes ❑ No If yes, Employer _____ Contact _____

Work Comp Carrier _____ Contact _____

INFORMATION NEEDED

Please include all the information below.

- ❑ Provider Notes
- ❑ Procedure Reports
- ❑ Appropriate Laboratory Reports
- ❑ Appropriate Imaging Reports
- ❑ Medication and Allergy Lists

Please indicate specialty needed for referral.

_____

Preferred Provider

_____

Appointment Urgency

- ❑ First available
- ❑ Urgent

REFERRING PROVIDER

Name _____ NPI _____

Address _____ City _____ State/Zip_____

Phone _____ Fax _____

Signature _____ Date _____

REFERRING RESPONSE

❑ Patient Scheduled

Provider_____ Date _____ Time _____

Comment_____

❑ Patient NOT Scheduled

Additional Information Required _____

Other Reason_____