PULMONARY PHYSICIANS
of norwich

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Diseases of the Chest, Respiratory Tract, and Critical Care

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REFERRAL FORM

Patient Name: _____ **DOB:** _____

Patient's Insurance: _____ **Authorization #:** _____

REASON FOR REFERRAL:

☐ Consult ☐ Pre-Operative Consult ☐ Pulmonary Function Test (PFT)

Diagnosis: _____

_____

REFERRING PHYSICIAN INFORMATION:

Referring Physician: _____
PRINT AND SIGN (STAMPED SIGNATURE ACCEPTED)

NPI: _____ **UPIN:** _____

Address: _____

Phone: _____ **Contact Person:** _____ **Fax:** _____

PLEASE INCLUDE THE FOLLOWING:

- Demographics
- Insurance Information & Card
- Medication & Allergy List
- Recent Office Notes
- History & Physical
- Any Applicable Labs or Testing

Please complete and fax back Referral Form to our NORWICH office with requested records. We will contact the patient directly to schedule an appointment and then notify your office. Please note that without all applicable information we cannot see this patient at the scheduled time. Your cooperation in this matter is appreciated. Thank you for your referral.

Appointment Date & Time: _____ at _____

Consulting Physician: _____ Location: _____