



Pulmonary Referral Form

Phone: 414.266.6730 • Fax: 414.266.6742

Date: _____

Thank you for referring your patient to the Pulmonary Clinic. Please provide the following information and pertinent medical records so that we can provide the best and most timely service. Please call 414-266-6730 if you have questions or wish to speak with a Pulmonary Physician.

Your patient has an appointment scheduled with _____ for the first time on _____.

Patient Information:

Patient Name: _____
Date of Birth: _____
Parent/Guardian Name: _____
Patient Address: _____
Home Phone Number: _____
Work Phone Number: _____
Insurance Carrier: _____
Needs Referral: Yes No

Referring Provider Information:

Provider Name: _____
Provider Address: _____
Phone Number: _____
Fax Number: _____

Reason for referral (Please describe chief complaint):

- Asthma
- Shortness of breath
- Infant apnea
- Cystic fibrosis
- Cough
- Recurrent pneumonia
- Chest pain
- Airway evaluation
- Stridor
- Chest wall deformity
- Chronic lung disease/bronchopulmonary dysplasia
- Other _____

Pertinent past medical history: (Please attach recent clinic visit notes)

Evaluation that has already been completed: (Please include copies of prior x-ray studies)

**** Please fax this form to 414-266-6742 along with pertinent medical records.**

Please include any necessary insurance referral authorizations. **Thank you.**

Referring Provider Signature: _____ **Date/Time:** _____

OFFICE USE ONLY

Date Received: _____
 Referral Accepted Referral Denied
Date of Appointment: _____
Reason: _____
Referral status communicated to _____ on ____/____/____.