Children's Hospital of Wisconsin®

A member of Children's Hospital and Health System.

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 Date of Appointment: _____

☐ Referral Denied Reason: _____

Referral status communicated to _____ on _____/_____/_____.

Additional copies of this form can be found at www.chw.org

APPLY DT BARCODE STICKER
MD Referral Accepted DT 346
MD Referral Denied DT 9901