Pulmonary Consultants Referral Form

860 South Madison Street
Tupelo, MS 38801
Phone: 662-377-7150 Fax: 662-377-3804

Patient name: ____
Date of birth: ____
Social Security Number: ___________________________________
Address: ____
Contact number: ____

Patient's Insurance: _______________ ID#_____________________
Secondary insurance: ______________ ID#____________________
Tricare or VA (please specify) referral authorization number (appointment will not be made until we have authorization number): ______________________________
***OUR OFFICE DOES ACCEPT HUMANA MEDICARE ADVANTAGE- (OUT-OF-NETWORK) ***

Referring provider: ______________________ NPI#_______________
Address: ____
Clinic phone: ______________________ Fax: _____________________
Type of referral: Pulmonary________
Sleep________
Both_________
If referral is for sleep only and the patient is experiencing **ANY pulmonary issues at all, please select **both** so we can ensure patient is scheduled accordingly**
Diagnosis or reason for referral: _____________________________
CT or CXR? _______ Date of exam: ___________

PATIENT MUST BRING COPY OF CT/CXR ON DISC

Has patient been tested for COVID-19? ________
If yes, date of testing: _______ Results: ________

PLEASE ATTACH MEDICAL RECORDS, COPY OF CT/CXR REPORT AND OFFICE NOTES. NO APPT WILL BE SCHEDULED UNTIL RECEIVE REQUESTED INFORMATION.

Scheduled Appointment Information

Appointment date: _________ Time: _______ Provider: _______
Please arrive 30 minutes early for appointment.
Completed by: _____________________ Date:______________