Request for Consultation

Pulmonology Referral Request

Patient Information

Patient Name: _____ Date of Birth:_____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____
Insurance Company: _____ Alt Phone: _____

1. Is This an urgent pulmonary referral? † No † Yes
   If yes, reason for urgency _____

2. Please describe the patient's chief complaint and include onset and frequency:

_____

_____

Please select diagnosis:	Pre referral work up requirements by diagnosis:
† Asthma	X Asthma; chest x-ray (report), Allergy testing, notes from other consultants
† Apnea	X Sleep apnea; chest x-ray (report), soft tissue neck x-ray, NICU notes and discharge summary notes from other consultants
† BPD	X O2 dependent, >>BD(>>BD) Nreport)nt whees andzing, hospitalizawth Nrvrge