

PHYSICIAN REFERRAL FORM

PATIENT NAME: _____ D.O.B. _____

PLEASE EVALUATE PULMONARY FOR:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Abnormal CXR/CT | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other _____ | |

I would like North Atlanta Pulmonary & Sleep Specialists to evaluate and follow my patient for his/her Pulmonary disorder. Yes No

(Referring Physician)

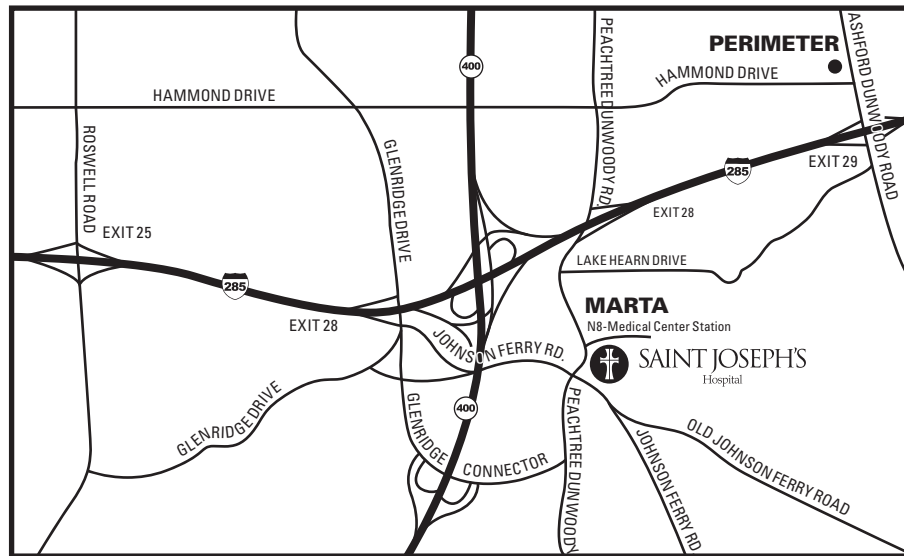
Address: _____

Phone: _____ Fax: _____

**PLEASE FAX THE FOLLOWING INFORMATION
WITH THE REFERRAL:**

- Current patient progress notes / H&P / CXR & CT reports
- ECHO / Stress Test reports
- Medication Sheet
- Patient information sheet
- Insurance card (front & back)
- Referral (if needed) for initial evaluation and follow up care
- Separate referral for Sleep testing

Vicinity Map



Campus Map

