

Referral Form Pulmonary Critical Care

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PLEASE FAX REFERRAL FORM, PATIENT DEMOGRAPHICS AND INSURANCE CARD(S) TO 505.727.3171

Patient name:		DOB:	
Home phone:	Cell phone:		
Insurance:			
Referring provider office name:	Referring pro	ovider office phone:	
Primary care provider name (if different	than referring):	PCP office phone:	
Reason for referral/request for consult	tation/order (check all that apply):		
☐ Asthma	☐ Lung cancer screening	☐ Respiratory distress	
☐ BiPAP or CPAP patient	☐ Lung mass/nodule	☐ Restrictive lung disorder (scoliosis)	
☐ Bronchopulmonary dysplasia	☐ Neuromuscular disorders	□ Second opinion	
☐ Central apnea	☐ Obstructive sleep apnea	☐ Sleep evaluation	
☐ Chronic cough	□ PFT	☐ Tracheostomy and/or ventilator patients	
☐ Chronic lung disease	☐ Pulmonary hypertension	☐ Wheezing	
☐ Cystic fibrosis	☐ Recurrent or persistent pneumonia	☐ Special/other	
Evaluations that may have already be	en completed:		
When	Where		
Please include relevant discs or films	s of previous chest x-rays.		
Provider signature:			
☐ I would like copies of all document	ation associated with this service.		
☐ Please DO NOT copy my office on t	this service documentation, only provide a cour	tesy phone call regarding diagnosis.	
Provider signature: I would like copies of all document Please DO NOT copy my office on t	ation associated with this service.		

WE GLADLY ACCEPT MOST INSURANCE PLANS, including Blue Cross and Blue Shield of New Mexico, Molina, TRICARE, Medicare, Medicaid, UnitedHealthcare Community Plan, New Mexico Health Connections, True Health New Mexico and United Retiree Health Care Authority and many others.



