# Referral Form Pulmonary Critical Care

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**PLEASE FAX REFERRAL FORM, PATIENT DEMOGRAPHICS AND INSURANCE CARD(S) TO 505.727.9328**

Patient name: _____ DOB: _____

Home phone: _____ Cell phone: _____

Insurance: _____

Referring provider office name: _____ Referring provider office phone: _____

Primary care provider name (if different than referring): _____ PCP office phone: _____

Reason for referral/request for consultation/order (check all that apply):

- ❑ Asthma
- ❑ BiPAP or CPAP patient
- ❑ Bronchopulmonary dysplasia
- ❑ Central apnea
- ❑ Chronic cough
- ❑ Chronic lung disease
- ❑ Cystic fibrosis
- ❑ Lung cancer screening
- ❑ Lung mass/nodule
- ❑ Neuromuscular disorders
- ❑ Obstructive sleep apnea
- ❑ PFT
- ❑ Pulmonary hypertension
- ❑ Recurrent or persistent pneumonia
- ❑ Respiratory distress
- ❑ Restrictive lung disorder (scoliosis)
- ❑ Second opinion
- ❑ Sleep evaluation
- ❑ Tracheostomy and/or ventilator patients
- ❑ Wheezing
- ❑ Special/other_____

Evaluations that **may have** already been completed:

| When | Where |
|---|---|
| _____ | _____ |
| _____ | _____ |

*Please include relevant discs or films of previous chest x-rays.*

Provider signature: _____

❑ I would like copies of all documentation associated with this service.

❑ Please DO NOT copy my office on this service documentation, only provide a courtesy phone call regarding diagnosis.

*We accept most major insurance plans, including Blue Cross and Blue Shield of New Mexico, Aetna Medicare & Commercial, TRICARE, Medicare, all Centennial/Medicaid plans, including Presbyterian Centennial Care, Western Sky Community Care and New Mexico Retiree Health Care Authority and many others..*



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