

# 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):

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

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

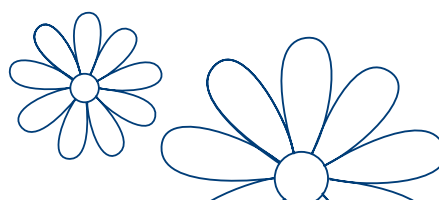
When	Where
_____	_____
_____	_____

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..*



# Lovelace Medical Group