ONSLOW PULMONOLOGY ASSOCIATES

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Referral Form:

Please fill out this form completely and fax to the number above

Physician Making Referral: _____ Phone: _____
Facility: _____ Fax: _____
Please Schedule (select all that apply):
☐ Urgent—Referring physician called: _____
☐ Routine Appointment with Specific Physician Listed: _____
☐ First available with any physician

Patient Name: _____ DOB: _____
Patient Phone:
Home: _____ Cell: _____
Insurance: 1.) _____
2.) _____
3.) _____ Authorization #: _____
If Medicaid:
NPI : _____ Number of Visits: _____
Referral is valid until: (Date) _____
Reason for Referral(Please include ICD10): _____

Please include relevant records, radiology reports, and demographics with this referral

Has the patient received prior care for this condition? Yes ☐ No ☐ If yes, please attach notes.

Has the patient had X-rays/MRI/CT done? Yes ☐ No ☐ Where: _____

Please have patient bring radiology disc to appointment.

We accept most insurance carriers.

Thank you for your referral.

We look forward to serving your patient and will call the patient to set up an appointment.

Apt. Date: _____Time:_____

- Patient declined apt.
- Unable to contact patient. (after 3 phones calls and a written letter)