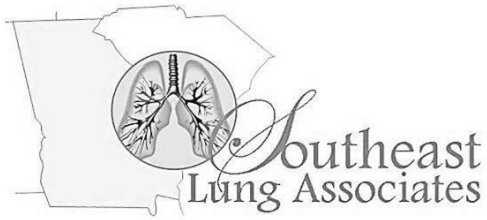
REQUEST FOR CONSULTATION



Please complete this form and fax it back to the appropriate fax number. Be sure to include the patient's medical record information and insurance card.

▢ STAT (1 day) ▢ Soon (2–5 days)
▢ Routine

▢ Masood Ahmed, MD	Fax 912.927.6899	Phone 912.349.7169
▢ Robert Burnaugh, MD	Fax 843.682.3597	Phone 843.682.3583
▢ James A. Daly, III, MD	Fax 912.927-6899	Phone 912.629.2290
▢ Randall B. Evans, MD	Fax 843.682.3597	Phone 843.682.3583
▢ Gifford Lorenz, MD	Fax 912.927.6899	Phone 912.352.4777
▢ Maria Mascolo, MD	Fax 912.826.3931	Phone 912.826.3927
▢ J. Allen Meadows, III, MD	Fax 912.927.6899	Phone 912.927.6270
▢ C. Adam McCoy, MD	Fax 912.927.6899	Phone 912.927.6270
▢ Ryan Moody, MD	Fax 912.927.6899	Phone 912.927.6270
▢ M. Douglas Mullins, MD	Fax 912.927.6899	Phone 912.819.5757
▢ Michael P. Perkins, MD	Fax 912.927.6899	Phone 912.927.6270
▢ M. Judith Porter, MD	Fax 912.927.6899	Phone 912.629.2290
▢ Obaid Rehman, MD	Fax 912.927.6899	Phone 912.927.6270

▢ No Provider Preference – first available Fax 912.927.6899

PATIENT INFORMATION

Name _____
Address _____
City _____ State _____ ZIP _____
DOB _____/_____/_____
Parent/Guardian _____
Employer _____
Employer's Telephone ( ) _____

Patient's Day Phone ( ) _____
Mobile Phone ( ) _____
E-Mail _____

PRIMARY INSURANCE (or attach insurance card) _____
Policy Holder Name _____
Policy # _____

SECONDARY INSURANCE(or attach insurance card) _____
Policy Holder Name _____ Policy # _____

Prior sleep study performed? _____
Patient on CPAP? _____
Current Smoker? _____
Recently hospitalized (within 6 months)? _____
Recent labs or radiology in past 3 months? _____
Diagnostic procedures in the last 12 months? _____

REFERRING PHYSICIAN INFORMATION

Name _____ Address
City _____ State _____ ZIP _____ Contact Person _____

Referring Provider's NPI _____
Phone ( ) _____
Fax ( ) _____

REASON CONSULTATION REQUESTED

- ▢ Asthma
- ▢ Abnormal Chest X-Ray
- ▢ COPD
- ▢ Hemoptysis
- ▢ Lung Cancer
- ▢ Lung Nodule
- ▢ Pleural Effusion
- ▢ Pulmonary Hypertension
- ▢ Shortness of Breath
- ▢ Obstructive Sleep Apnea
- ▢ Insomnia
- ▢ Other _____

Special Instructions

INTEROFFICE USE:

Date of Appointment _____ *Time* _____ *AM/PM*

Location _____

Scheduled by _____

Date Scheduled _____

MD Office Appointment Confirmed? ▢ *Yes* ▢ *No*
By _____

New patient information packet mailed or patient agreed to complete online? ▢ *Yes* ▢ *No*
By _____

6-8-2016

THANK YOU FOR YOUR KIND REFERRAL.