

# 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 with Physician to Physician Contact Required)
- Urgent (2-5 days)       Routine

- |  |                  |                    |
|--|------------------|--------------------|
| <input type="checkbox"/> Masood Ahmed, MD          | Fax 912.927.6899 | Phone 912.349.7169 |
| <input type="checkbox"/> Robert Burnaugh, MD       | Fax 843.682.3597 | Phone 843.682.3583 |
| <input type="checkbox"/> James A. Daly, III, MD    | Fax 912.927-6899 | Phone 912.629.2290 |
| <input type="checkbox"/> Randall B. Evans, MD      | Fax 843.682.3597 | Phone 843.682.3583 |
| <input type="checkbox"/> Gifford Lorenz, MD        | Fax 912.927.6899 | Phone 912.352.4777 |
| <input type="checkbox"/> Maria Mascolo, MD         | Fax 912.826.3931 | Phone 912.826.3927 |
| <input type="checkbox"/> J. Allen Meadows, III, MD | Fax 912.927.6899 | Phone 912.927.6270 |
| <input type="checkbox"/> C. Adam McCoy, MD         | Fax 912.927.6899 | Phone 912.349.7169 |
| <input type="checkbox"/> Ryan Moody, MD            | Fax 912.927.6899 | Phone 912.927.6270 |
| <input type="checkbox"/> M. Douglas Mullins, MD    | Fax 912.927.6899 | Phone 912.819.5757 |
| <input type="checkbox"/> Michael P. Perkins, MD    | Fax 912.927.6899 | Phone 912.927.6270 |
| <input type="checkbox"/> M. Judith Porter, MD      | Fax 912.927.6899 | Phone 912.629.2290 |
| <input type="checkbox"/> Obaid Rehman, MD          | Fax 912.927.6899 | Phone 912.927.6270 |
| <input type="checkbox"/> Craig Schuring, DO        | 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 # \_\_\_\_\_

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? \_\_\_\_\_

## SECONDARY INSURANCE (or attach insurance card)

Policy Holder Name \_\_\_\_\_ Policy # \_\_\_\_\_

## 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 \_\_\_\_\_