bay area pediatric pulmonary
medical corporation

NEW PATIENT REFERRAL QUESTIONNAIRE

Referring PMD: _____

Address: _____

Office Telephone: _____

Patient's Name:	**Date of Birth:**
	Age:

Parent's Name: _____ Address:_____

Home Telephone: _____ Work: _____

Insurance: _____ Medical Group: _____

*****PLEASE INCLUDE COPY OF INSURANCE CARD*****

Authorization/Referral: _____
THE HARD COPY OF THE AUTHORIZAITON MUST BE FAXED WITH THIS FORM.
PLEASE REQUEST CPT CODES: 99245 (NEW CONSULT) AND 94375 (PFT 6 YRS+), 94664 (for possible teaching/demo of equip) & 94760 (O2 Sat)

Chief Complaint: _____

History of Present Illness: _____

Date of Last Exam: _____ Exam Findings: _____

Pertinent PMH: _____

Treatment tried so far: _____

Preliminary Diagnosis: _____

How soon does patient need to be seen? _____ Routine (CHO, 3-4 mo, CPMC/Marin 2-6 mo)
_____ Emergent (1 week) _____ Urgent (2 weeks)

☐ **I wish for the patient to be seen in your Sleep Clinic.**

IF EMERGENT OR URGENT, THE PHYSICIAN MUST CALL OUR OFFICE NUMBER ABOVE TO SPEAK TO A PULMONOLOGIST.

Diagnostic test determination will be made by the pulmonologist at time of visit. If you are interested in any testing prior to this visit, please consult with the pulmonologist assigned to the patient.

*****PLEASE INCLUDE CLINIC NOTES, LABS, IMAGING SPECIAL STUDIES, OTHER CONSULTS, AND GROWTH CHARTS*** PATIENTS WILL NOT BE SCHEDULED UNTIL COMPLETED FORM, AUTHORIZATION, AND RELEVANT REPORTS ARE RECEIVED.**

FAX TO: PEDIATRIC PULMONARY (510) 597-7154.

t (510) 428-3305 747 52nd Street Suite 5409 Oakland, California 94609 f (510) 597-7154