TARRANT PULMONARY ASSOCIATES
PATIENT REFERRAL FORM

Reason for Consultation: _____

Other Diagnoses: _____

Return by fax to the location's fax number along with recent office notes, CXR/CT reports, labs and patient's insurance card(s). If patient has had CXR/CT, please have patient bring CD.

Patient:

Last Name: _____ First Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

SS# _____ Sex: _____ DOB: _____

Referring Doctor: _____ Contact: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Would you like us to contact you or the patient with appointment information? Yes / No

Primary Care Physician: _____

Primary Insurance Policy:

Insurance Co. _____ ID No. _____ Group No. _____

Name of Insured _____ Relationship to patient _____

Insured's DOB _____ SSN _____ Sex _____

Claims Mailing Address _____

Phone No. _____

Secondary Insurance Policy:

Insurance Co. _____ ID No. _____ Group No. _____

Name of Insured _____ Relationship to patient _____

Insured's DOB _____ SSN _____ Sex _____

Claims Mailing Address _____

Phone No. _____

_____ _____

Signature of Ordering Physician ***Date***

For office use only:

Appointment date/time _____ With: _____ Schedule by: _____

Pt contacted: _____ Dr. office contacted: _____ Pprwk mailed: _____

Pt to arrive @ _____ CPFT @ _____ ☐ Requested CD from: _____