Christiana Care Pulmonary Associates

PHYSICIAN'S REFERRAL FORM

Attn: Amanda
FAX to: (302)328-7313

Date: _____

Patient Name: _____
Patient Date of Birth: _____

Patient Telephone Number: Contact 1: (_____) _____-_____ Best Time to Call: _____
Contact 2: (_____) _____-_____

Primary Insurance: _____ Secondary Insurance: _____

Diagnosis / Reason for Referral: **(NOTE – please use the space below to give a brief medical history of your patient and the reason for their referral.)**

_____

_____

_____

_____

Physician's / Contact Person's Name: _____

Office Telephone: _____ Office Fax: _____

PLEASE ENSURE THAT THE FOLLOWING RECORDS ARE ATTACHED WHEN FAXING THIS REFERRAL FORM:

- ☐ Patient Demographics (to include name, SSN, address, emergency contact)
- ☐ Copy of patient's insurance card(s)
- ☐ Pertinent Medical Records (to include recent radiology reports and breathing tests)
- ☐ Insurance Referrals (if applicable)

PULMONARY ASSOCIATES USE ONLY

Patient Contacted YES NO If NO, comment: _____

_____

Appointment Information:

Date _____ Time _____ Provider _____

Location CCHS WILM Comment _____

_____