



TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

PATIENT REFERRAL

Date: _____

Reason for Consultation: _____

Other Diagnoses: _____

Please check physician to whom the patient is being referred: or First Available

<input type="checkbox"/> Steven Davis, M.D.	<input type="checkbox"/> David Hernandez, M.D.	<input type="checkbox"/> John Burk, M.D.	<input type="checkbox"/> Kerim Razack, M.D.
<input type="checkbox"/> Roger Gleason, M.D.	<input type="checkbox"/> John Pender, M.D.	<input type="checkbox"/> Stuart McDonald, M.D.	
1201 Fairmount Avenue, Fort Worth, TX 76104 817-335-5288 Fax 817-338-0927		1521 Cooper Street, Fort Worth, TX 76104 817-336-5864 Fax 817-336-2159	

Patient Information:

Last Name: _____ First Name/Middle Initial: _____
 Address: _____ City/State/Zip: _____
 Home Phone: _____ Sex: M F Marital Status: M S D W
 Cell Phone: _____ SS#: _____ DOB: _____
 Employer: _____ Phone: _____

**** Please fax front and back of current insurance card(s) ****

Referring Doctor: _____ NPI: _____
 Address: _____ City/State/Zip: _____
 Phone: _____ Fax: _____
 Specialty: _____ Office Contact: _____

Primary Care Physician: _____ NPI: _____
 PCP Phone: _____ PCP Fax: _____

Provide any and all of the following:

- | | |
|--------------------------|----------------------------|
| CT Chest/Abdomen Reports | Results of Recent Lab Work |
| Chest X-ray Reports | Latest Dictation |
| Echocardiogram Report | Pulmonary Function Reports |

The patient will not be scheduled until a current referral is authorized, if applicable. Otherwise, we will notify the patient of the appointment date and time.

Signature of Ordering Physician

Date

Appointment Date: _____	With: _____	Scheduled by: _____ (Initials)
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