



TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

PATIENT REFERRAL

Date: _____

Reason for Consultation: _____

Other Diagnoses: _____

Physician to whom the patient is being referred:

Joseph Austin, M.D.	Jack G. Gilbey Jr, M.D.	Luis F. Guerra, M.D.	E. Duane Dilley, M.D.	Phan T. Nguyen, M.D.
Mitchell Kuppinger, M.D.	David H. Plump, M.D.	Tony H. Su, M.D.		
911C Medical Centre Drive, Arlington, TX 76012 817-461-0201 Fax 817-861-3365			601 Omega Drive, Suite 206, Arlington, TX 76014 817-465-5881 Fax 817-465-6336	

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: _____

Referring Doctor: _____ NPI: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Specialty: _____ Office Contact: _____

Would you like us to contact you or the patient with appointment information? _____

Primary Care Physician: _____ NPI: _____

PCP Phone: _____ PCP Fax: _____

PRIMARY INSURANCE POLICY:

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

Name of Insured _____ Relationship to patient _____

Insured's Birth Date _____ SSN _____ Sex _____

Claims Mailing Address _____

Phone No. _____

SECONDARY INSURANCE POLICY:

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

Name of Insured _____ Relationship to patient _____

Insured's Birth Date _____ SSN _____ Sex _____

Claims Mailing Address _____

Phone No. _____

Signature of Ordering Physician _____

Date _____

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