Pulmonary and Sleep Evaluation Referral Form

A MEMBER OF BAPTIST MEMORIAL MEDICAL GROUP
MEMPHIS LUNG

From Dr. _____ Date: _____

Dr.'s Phone: _____ Dr.'s Fax: _____

Contact Person: _____ Contact Phone: _____

Contact email: _____

Preferred contact method: ☐ Phone ☐ Fax ☐ Email

Complete this form and fax to the location of your choice. Our staff will contact your patient to schedule the appointment and will notify your office with an appointment confirmation.

If preferred, you may also email your request and office notes to ***Referrals@MemphisLung.com***

☐ MEMPHIS
FAX: 901-767-6591
6025 Walnut Grove Rd.
Suite 508
Memphis, TN 38120
PH: 901-767-5864

☐ SOUTHAVEN
FAX: 662-349-5974
401 Southcrest Circle
Suite 212
Southaven, MS 38671
PH: 662-349-0488

☐ COLLIERVILLE
FAX: 901-850-1169
1500 W Poplar Ave.
Suite 309
Collierville, TN 38017
PH: 901-850-1170

☐ BMG UNION AVE
(satellite location)
FAX: 901-767-6591
1520 Union Ave.
Memphis, TN 38104
PH: 901-767-5864

Patient Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Insurance Information

Primary Insurance: _____ ID# _____

Secondary Insurance: _____ ID# _____

Reason for Referral

☐ Pulmonary _____ ☐ Sleep Evaluation ☐ Pulmonary Hypertension

☐ Pulmonary Function Testing (PFT) ☐ Cardio/Pulmonary Exercise Testing (CPET) ☐ Bronchoscopy

Additional Comments

_____

_____

_____

_____

Please provide the following:

- Current office notes
- Copy of insurance card
- Most recent lab work
- EKG or Echo results
- X-Ray or CT report
- Copy of X-ray or CT if NOT done at a Baptist facility

Appointment Confirmation

Your patient has an appointment scheduled with Dr. _____

Date: _____ Time: _____ AM / PM

Thank you for your referral!

v 1.4