A MEMBER OF BAPTIST MEMORIAL MEDICAL GROUP

MEMPHIS LUNG

Pulmonary and Sleep Evaluation Referral Form

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***

☐ **GERMANTOWN**
FAX: 901-767-6591
2120 Exeter Road, Suite 250
Germantown, TN 38138
PH: 901-767-5864

☐ **SOUTHAVEN**
FAX: 662-349-5974
363 Southcrest Circle, Suite 201
Southaven, MS 38671
PH: 662-349-0488

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!