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 or email to MLReferral@bmhcc.org.
Our staff will contact your patient to schedule the appointment and will notify your office with an appointment confirmation.

❑ GERMANTOWN	❑ SOUTHAVEN	❑ COLLIERVILLE	❑ ATOKA
FAX: 901-767-6591	**FAX: 662-349-5974**	**FAX: 901-767-6591**	**FAX: 901-767-6591**
2120 Exeter Road, Suite 250	**363 Southcrest Circle, #201**	**1500 W. Poplar Ave, Suite 309**	**76 Capital Way Cv, Suite B**
Germantown, TN 38138	**Southaven, MS 38671**	**Collierville, TN 38017**	**Atoka, TN 38004**
PH: 901-767-5864	**PH: 662-349-0488**	**PH: 901-767-5864**	**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

_____

_____

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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!