LOUISVILLE PULMONARY CARE, PLLC

4003 Kresge Way Suite 312 Louisville, Kentucky 40207

502-899-7377 Fax 502-899-5832

Patient Referral Form

****If patient has PASSPORT insurance, they Must be referred by the PCP, it has to be stated in PCP office notes that they are referring patient for specific diagnosis****

Patient Name:_____

Patient DOB:_____Social Security#_____

Patient Phone Number:_____Cell or work:_____

Reason for Referral:_____

Patient Insurance:_____

Referring MD:_____PCP:_____

Referring MD Phone Number:_____Fax #:_____

Contact Person at Referring MD office:_____

Please fax the following information to our office at (502) 899-5832

*Patient Demographics

*Copy of patient's insurance cards

*All imaging reports (PFT, CXR, CT, MRI, etc.) Please circle or add all that apply

*Last 2 Office notes with clear reason for appt

*Medication list

Preferred Physician:_____or 1st available_____

For office Use Only: Appt date/Time:_____M.D._____