**NMMC Pulmonary Referral Form**

**Tupelo Pulmonary Consultants**  **Amory Pulmonary Consultants Starkville Pulmonary Clinic**

860 South Madison Street 1107 Earl Frye Blvd Suite 4 1207 Hwy 182 West, Suite E

Tupelo, MS 38801 Amory, MS 38821 Starkville, MS 39759

Phone: 662-377-7150 Phone: 662-305-8657 Phone: 662-465-2126

Fax: 662-377-3804 Fax: 662-305-8658 Fax: 662-465-2127

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tricare or VA (please specify) referral authorization number (appointment will not be made until we have authorization number):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*\*\*OUR OFFICE DOES ACCEPT HUMANA MEDICARE ADVANTAGE- (OUT-OF-NETWORK)\*\*\*

Referring provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of referral: Pulmonary\_\_\_\_\_\_\_\_

 Sleep\_\_\_\_\_\_\_\_

 Both\_\_\_\_\_\_\_\_\_

 Lung nodule clinic\_\_\_\_\_\_\_\_\_ (Tupelo and Starkville locations)

\*\*If referral is for sleep only and the patient is experiencing **ANY** pulmonary issues at all, please select **both** so we can ensure the patient is scheduled accordingly\*\*

Diagnosis or reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CT or CXR? \_\_\_\_\_\_\_ Date of exam: \_\_\_\_\_\_\_\_\_\_\_

**PATIENT MUST BRING COPY OF CT/CXR ON DISC**

PLEASE ATTACH MEDICAL RECORDS, COPY OF CT/CXR REPORT AND OFFICE NOTES. NO APPT WILL BE SCHEDULED UNTIL RECEIVE REQUESTED INFORMATION.

 Scheduled Appointment Information

Appointment date: \_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_ Provider: \_\_\_\_\_\_\_

Please arrive 30 minutes early for appointment.

Completed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_