Tucson
Pulmonology, PC

FAX Cover Sheet
(520) 344-6938

New Patient Referral

Date: ___________________

Patient Name: __________________________ Date of Birth: __________________

Home Phone: __________________________ Cell Phone: ____________________

Address: ____

Primary Insurance: _______________________ ID: ___________________________

Secondary Insurance: _____________________ ID: ___________________________

Reason for Referral (must be pulm/sleep diagnosis): ____

ICD-10: ____

Please send the following if available, please cross off items not available:

____ Progress Notes ____ Lab Results ____ Chest X-ray

____ CT Chest ____ PET Scan ____ Echo Report

____ Sleep Studies ____ PFT Tests ____ TB tests (PPD skin or lab)

____ Medication List ____ Other (please specify): ___________________________

____ Copy of Insurance card(s) ____ Referral (with authorization if required)

Providing the above information assists with scheduling patients, we appreciate your assistance with providing this information

Referring Provider: _______________________ NPI/Tax ID: __________________________

Direct Messaging address: ____

PCP (if different): _________________________ NPI/Tax ID: ___________________________

Location requested:

____ East Clinic: 6567 E Carondelet Dr, Suite 215, Tucson, AZ 85710

____ West Clinic: 1773 W St. Mary's Road, Suite 201, Tucson, AZ 85745

WE THANK YOU FOR YOUR REFERRAL. PLEASE DO NOT HESITATE TO CONTACT US WITH QUESTIONS AT (520) 885-1402.

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