

PENINSULA PULMONARY ASSOCIATES, P.A.
FAX: 410-543-7725

CONSULTATION REQUEST BY FAX

Referring Dr.: _____ Primary Dr. _____

Phone: _____ Phone: _____

Fax: _____ Contact Person: _____

Pt's Name: _____ (Male/Female)

SS #: _____ DOB: _____

Home Ph.: _____ Wk/Alt Ph: _____

Address: _____

Primary Ins/Policy #: _____

Referral required?: YES NO Authorization required?: YES NO

2ndary Ins/Policy #: _____

Referral required?: YES NO Authorization required?: YES NO

****If referral/ authorization required for pulmonary testing and/or chest x-ray,
please fax to 410-543-7725.****

**PLEASE FAX COPIES OF ALL PERTINENT MEDICAL RECORDS, COPIES OF INSURANCE
CARDS, REFERRALS AND THE CONSULTATION REQUEST TO OUR OFFICE.**

REASON FOR CONSULT: _____

When and where was the last chest x-ray?: _____

When and where was the last pulmonary function study?: _____

All pulmonary consults will be scheduled with the next available physician; all sleep
consults with the next available nurse practitioner. If a specific practitioner is requested
by the referring physician or the patient, indicate here: _____

*******If you do not receive a reply within one business day,
please re-fax or call 410-749-8860.*******

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