Patient Referral Form

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Indiana University Health Arnett Pulmonary Diseases & Critical Care

Referring Physician: ______________________ Physician Signature: ______________________

Phone: ______________________ Fax: ______________________

Pulmonologist: ______________________

Appointment Date: ______________________ Time: ______________________

Patient Name: ______________________ Phone: ____________ MRN (or DOB): __________

Diagnosis for referral:

- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Cough
- ☐ Hemoptysls
- ☐ Interstitial Lung Disease
- ☐ Lung Infiltrate
- ☐ Lung Mass/Nodule
- ☐ Lung Cancer
- ☐ Pleural Effusion
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Pulmonary Hypertension
- ☐ Shortness of Breath
- ☐ Sleep Disturbance
- ☐ Other: ______________________

Check one:

- ☐ Opinion (consult only)
- ☐ Take over management of pulmonary condition (new patient)

Please fax the following Information, If available, before the appointment:

- ☐ Chest X-ray
- ☐ PFT
- ☐ CT-Chest
- ☐ Progress note
- ☐ Labs
- ☐ Sleep Study

ADDITIONAL INFORMATION

☐ YES ☐ NO Has the patient ever been hospitalized for lung or breathing issues? If yes, please fax records.
Date: ______________ Where: ______________ Diagnosis: ______________

☐ YES ☐ NO Has the patient ever had a sleep study? If yes, please fax records.
Date: ______________ Where: ______________

☐ YES ☐ NO Does the patient have a CPAP or BIPAP? DME: ______________________

☐ YES ☐ NO Does the patient wear oxygen? Liter flow: ______ When patient wears: __________ DME: ________

☐ YES ☐ NO Has the patient had a flu vaccine? Date: ______________ Where: ______________

☐ YES ☐ NO Has the patient had a pneumonia vaccine? Date: ______________ Where: ______________

We appreciate your referral. Please contact us if you have questions regarding referrals to IU Health Arnett Pulmonary Diseases & Critical Care. Please note that incomplete submission of this referral form my result in a delay contacting your patient.

Arnett Physicians

iuhealth.org/arnettreferral

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