TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

PATIENT REFERRAL

Date: _____

Reason for Consultation: _____

Other Diagnoses: _____

Please select the intended physician or location for the referral:

☐ **R. L. "Lin" Cash, Jr., M.D., FCCP**
☐ **James T. Siminski, M.D., FCCP**

☐ **First Available This Location**
911C Medical Centre Drive
Arlington, Texas 76012
(817) 461-0201 (Metro)
(817) 861-3365 Fax

☐ **Ariffin Alam, M.D.**
☐ **Jonathan Besas, D.O.**
☐ **John R. Burk, M.D., FACP**
☐ **Kevin G. Connelly, M.D., FCCP**
☐ **Huy X. Duong, D.O., FCCP**
☐ **Sai Karan Vamsi Guda, D.O.**
☐ **Abigale D. Henry, M.D.**
☐ **John W. Hollingsworth, II, M.D., FCCP**
☐ **Stuart D. McDonald, M.D., FCCP**
☐ **Andrew L. Miller, M.D.**
☐ **Kerim F. Razack, M.D., FCCP**
☐ **Muhammad Hasham Sarwar, M.D.**
☐ **Ramesh Subedi, M.D.**

☐ **First Available This Location**
1201 Fairmount Avenue
Fort Worth, Texas 76104
(817) 335-5288
(817) 394-3994 New Patient Referrals Fax

☐ **Mitchell C. Kuppinger, M.D.**
2941 Oak Park Circle, Suite 200
Fort Worth, Texas 76109
(817) 332-7433
(817) 394-6282 Fax

Return this form by fax to the location's fax number along with recent office notes, CXR/CT reports, labs and patient's insurance card(s). If patient has had CXR/CT, please have patient bring CD.

Patient:
Last Name:_____ First Name/Middle Initial:_____
Address:_____ City/State/Zip:_____
Home Phone:_____ Cell Phone: _____ SS#:_____
Sex: _____ Marital Status: _____ DOB:_____
Email Address: _____
Employer:_____ Employer Phone:_____

Referring Provider:_____ Contact Person: _____
NPI: _____
Address:_____ City/State/Zip:_____
Phone:_____ Fax: _____

Would you like us to contact you or the patient with appointment information?_____

Primary Care Provider:_____
NPI: _____
Address:_____ City/State/Zip:_____
Phone:_____ Fax: _____

PRIMARY INSURANCE POLICY:
Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Relationship to patient _____
Insured's DOB _____ SSN _____ Sex _____
Claims Mailing Address _____
_____ Phone No. _____

SECONDARY INSURANCE POLICY:
Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Relationship to patient _____
Insured's DOB _____ SSN _____ Sex _____
Claims Mailing Address _____
Phone No.

_____ _____
Signature of Ordering Provider Date