TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

PATIENT REFERRAL

Date: _____

Reason for Consultation: _____

Other Diagnoses: _____

Please check physician to whom the patient is being referred: **or ❑ First Available**

❑ **Samer Fahoum, M.D.** ❑ **Obinna Okoye, M.D.** ❑ **Roger Gleason, III, M.D.** ❑ **John Pender, Jr, M.D.** ❑ **John Hollingsworth, II, M.D.** 1201 Fairmount Avenue, Fort Worth, TX 76104 817-335-5288 **Fax 817-338-0927**	❑ **John Burk, M.D.** ❑ **Stuart McDonald, M.D.** ❑ **Vikas Goyal, M.D.** ❑ **Harpreet Suri, M.D.** ❑ **Steven Kim, M.D.** 1521 Cooper Street, Fort Worth, TX 76104 817-336-5864 **Fax 817-336-2159**

Patient Information:

Last Name:_____ First Name/Middle Initial: _____
Address:_____ City/State/Zip: _____
Home Phone:_____ Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ D ❑ W
Cell Phone:_____ SS#:_____ DOB: _____
Email Address: _____
Employer:_____ Phone: _____

**** Please fax front and back of current insurance card(s) ****

Referring Doctor:_____ NPI: _____
Address:_____ City/State/Zip: _____
Phone:_____ Fax: _____
Specialty:_____ Office Contact: _____

Primary Care Physician:_____ NPI: _____
PCP Phone:_____ PCP Fax:_____

Provide any and all of the following:

- CT Chest/Abdomen Reports
- Chest X-ray Reports
- Echocardiogram Report
- Results of Recent Lab Work
- Latest Dictation
- Pulmonary Function Reports

The patient will not be scheduled until a current referral is authorized, if applicable. Otherwise, we will notify the patient of the appointment date and time.

_____ _____
Signature of Ordering Physician Date

FOR OFFICE USE
Appointment Date: _____ With:_____ Scheduled by:_____(Initials)