TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

PATIENT REFERRAL

Date: _____

Reason for Consultation: _____

Other Diagnoses: _____

Physician to whom the patient is being referred (circle):

Joseph Austin, M.D. Jack G. Gilbey Jr, M.D. Luis F. Guerra, M.D. **Edward W. Mims, M.D. David H. Plump, M.D. Tony H. Su, M.D.** 911C Medical Centre Drive, Arlington, TX 76012 817-461-0201 Fax 817-861-3365	**Phan T. Nguyen, M.D.** 601 Omega Drive, Suite 206, Arlington, TX 76014 817-465-5881 Fax 817-465-6336

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: _____

Employer:_____ Phone: _____

Referring Doctor:_____ NPI: _____

Address:_____ City/State/Zip: _____

Phone:_____ Fax: _____

Specialty:_____ Office Contact: _____

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

Primary Care Physician:_____ NPI: _____

PCP Phone:_____ PCP Fax:_____

PRIMARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____

Name of Insured _____ Relationship to patient _____

Insured's Birth Date _____ SSN _____ Sex _____

Claims Mailing Address _____

_____ Phone No. _____

SECONDARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____

Name of Insured _____ Relationship to patient _____

Insured's Birth Date _____ SSN _____ Sex _____

Claims Mailing Address _____

_____ Phone No. _____

_____ _____

Signature of Ordering Physician Date

Appointment Date: _____ With:_____ Scheduled by: _____(Initials)