Emory Children's Center Pulmonary Medicine

New Patient Referral Form

PLEASE COMPLETE AND FAX TO (404) 712-9712

Thank you for referring ____ **(DOB)** ___________________ for a pulmonary evaluation at the Emory Children's Center. Please answer the following questions to assist with prompt scheduling of the patient. Patients will not be scheduled without this information. We will contact the parent/guardian with an appointment within two business days from receipt of this form.

**** PLEASE ATTACH INSURANCE INFORMATION ****

Parent/Guardian name: ___________________________________ **Home phone**: _____________________

Address: ___________________________________ **Work Phone**: _____________________

___________________________________ **Other Phone**: _____________________

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Referring Physician: ___________________________________ **Phone**: _____________________

Address: ___________________________________ **Fax**: _____________________

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Please list all patient diagnoses:

Reason for Referral:

Labs/tests done for this reason:

Medications tried for this reason:

Urgency: **Please circle one and we will do our best to accommodate you**

Within 2 weeks   Within 2 months   1st available

** **FOR OFFICE USE ONLY** **

Teague Harsch Simon Golubic Fitzpatrick   Schedulers please return to Norma (7-1327)

Date/Time: _________________________   Appointment Date: ___________________

Or within _________ weeks   Appointment Time: ___________________