Providence
HEALTH

Providence Pulmonary and Sleep medicine
2750 Laurel Street Suite 200
Columbia SC, 29204
(803) 365 8680 Phone
(803) 227-4195 Fax

Date: ____/____/____

Referral Form

____Pulmonary Consultation **_____Sleep Consultation**

Patient Information-

First Name: _____ MI: ___ Last Name: _____

DOB: ____/____/____ SSN: _____-_____-_____ Sex: _____

Address: _____

City_____ State: _____Zip:_____

Home Phone: _____ Work Phone: _____ Mobile: _____

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Prior Auth required for office visits: _____Yes _____No If yes, Auth No._____

Consultation Information: Please include copies of notes, H&P, Ct, X-Ray, Labs and Med list

Referring Physician: _____Contact:_____

Phone: _____ Fax: _____

Reason for Consult: _____

_____

Priority: Routine Urgent