



5002 Cowhorn Creek Drive  
 Texarkana, Tx. 75503  
 Phone: (903) 614-3006  
 Fax: (903) 614-3522

### PULMONOLOGY

**CONSULT** (Request for advice / opinion) or  **REFERRAL** (Request for management of care)  
 (Please only select one request)

#### REQUESTING PROVIDER INFORMATION

Requesting Provider Name		Requesting Provider Address (street, city, state, zip)	
Requesting Provider Telephone	Requesting Provider Fax Number	NPI #	
(    )       -	(    )       -		

#### APPOINTMENT REQUEST

#### DIAGNOSIS

<input type="checkbox"/> <b>First Available</b> <input type="checkbox"/> <b>Malcolm Smith, MD</b>	
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\*\*\*\*\* DOCUMENTATION \*\*\*\*\*

*Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 614-3522. Thank you in advance for the request and your cooperation.*

#### PATIENT and INSURANCE INFORMATION

Patient Name (First, Middle Initial, Last)		Gender	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City, State, Zip	
Date of Birth (mm/dd/yyyy)	Social Security #		
/   /	-   -		
Home Telephone	Mobile Telephone	Work Telephone	
(    )       -	(    )       -	(    )       -       xtn	
Does patient need an interpreter?		If yes, what language?	
<input type="checkbox"/> Y <input type="checkbox"/> N			
Does the patient have medical insurance?		Name of Insurance Company and Plan Number and Group Number	
<input type="checkbox"/> Y <input type="checkbox"/> N			

Patient MR #	Patient ID #
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