CULLMAN REGIONAL | Medical Group

Darryle Bullard, MD — Pulmonology
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PULMONOLOGY REFERRAL FORM

Patient Name: _____

DOB: _____ Phone #: _____ Cell #: _____

Height: _____ Weight: _____

Address: _____

_____

Insurance Carrier: _____

Policy #: _____

Referral authorization # if required _____

Please include clinical documentation such as imaging, lab work, clinic notes, if available.

REASON FOR REFERRAL

	Alpha-1 Antitrypsin (AAT) deficiency		**Diseases of the Pleura**		Lung cancer
	Asthma		Pleural effusions		Lung masses
	Bronchiectasis		Mesothelioma		Occupational lung disease
	Chest pain		Asbestosis		Pulmonary fibrosis
	Chronic bronchitis		Aspergillosis		Pulmonary function testing
	Chronic cough		Pulmonary embolism		Pulmonary hypertension
	Chronic respiratory failure		Emphysema		Pulmonary nodules
	COPD		Hypersensitivity pneumonitis		Recurrent pneumonia
	Cystic fibrosis		Interstitial lung disease		Sarcoidosis
	Dyspnea		Idiopathic pulmonary fibrosis (IPF)		**Other:**

ORDERING PROVIDER

Physician: _____

Phone #: _____ Fax #: _____

Provider Signature: _____

Appointment Date/Time: _____ Patient notified on: _____

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures

Phone (256) 735-5175 Fax (256) 417-4269