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**