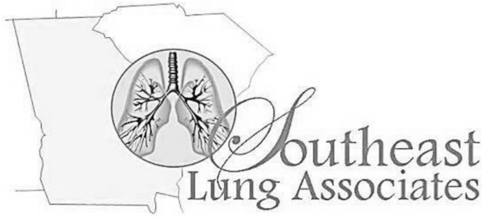
REQUEST FOR CONSULTATION



▢ Masood Ahmed, MD	Fax 833.301.1825	Phone 912.927.6270
▢ James A. Daly, III, MD	Fax 833.301.1824	Phone 912.629.2290
▢ Maria Mascolo, MD	Fax 833.301.1830	Phone 912.826.3927
▢ Ryan Moody, MD	Fax 833.301.1825	Phone 912.927.6270
▢ M. Douglas Mullins, MD	Fax 912.819.5753	Phone 912.819.5757
▢ M. Judith Porter, MD	Fax 833.301.1824	Phone 912.629.2290
▢ Obaid Rehman, MD	Fax 833.301.1825	Phone 912.927.6270

Please complete this form and fax it back to the appropriate fax number. Be sure to include the patient's medical record information and insurance card.

▢ No Provider Preference – first available Fax 833.301.1825

▢ STAT (1 day with Physician to Physician Contact Required)

▢ Urgent (2-5 days) ▢ Routine

PATIENT INFORMATION

Name ____

Address ____

City ______________________ State ________ ZIP __________

DOB _____/_____/_______

Parent/Guardian______________________________________

Employer ____

Employer's Telephone (   )_______________________

Patient's Day Phone (   ) _________________________

Mobile Phone (   ) ______________________________

E-Mail ____

Prior sleep study performed? _________

Patient on CPAP? ______

Current Smoker? ______

Recently hospitalized (within 6 months)? __________

Recent labs or radiology in past 3 months? _________

Diagnostic procedures in the last 12 months? ________

PRIMARY INSURANCE **(or attach insurance card)**______________________

Policy Holder Name ____________________________________

Policy # ____________________________

SECONDARY INSURANCE **(or attach insurance card)**___________________

Policy Holder Name _______________________________ Policy # _____________________________

REFERRING PHYSICIAN INFORMATION

Name ____ Address

City _____________________ State ______ ZIP _________ Contact Person ____

Referring Provider's NPI ______________________________

Phone (   ) ___________________________

Fax (   ) ___________________________

REASON CONSULTATION REQUESTED

- ▢ Asthma
- ▢ Abnormal Chest X-Ray
- ▢ COPD
- ▢ Hemoptysis
- ▢ Lung Cancer
- ▢ Lung Nodule
- ▢ Pleural Effusion
- ▢ Pulmonary Hypertension
- ▢ Shortness of Breath
- ▢ Obstructive Sleep Apnea
- ▢ Insomnia
- ▢ Other ____

Special Instructions

____

____

INTEROFFICE USE:

Date of Appointment ___________Time _______AM/PM

Location ____________________________________

Scheduled by ________________________________

Date Scheduled _____________________

MD Office Appointment Confirmed? ▢ *Yes* ▢ *No*

By ____________________________________

New patient information packet mailed or patient agreed to complete online? ▢ *Yes* ▢ *No*

By ____________________________________

2-1-2024

THANK YOU FOR YOUR KIND REFERRAL.