

**Pulmonary Clinic**  
**Pulmonary-Asthma Clinic**  
Fax 504.903.2149

Patient Label/Stamp

Referral from:  BMC  EKL  LJC  LAK  
 LIH  UMC  WOM  Other: \_\_\_\_\_

Attending Provider: \_\_\_\_\_ ID Number: \_\_\_\_\_

*If Label/Stamp is Not Available Complete the Following:*

Patient's Name: \_\_\_\_\_ Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical Record Number: \_\_\_\_\_

1° Contact Number: \_\_\_\_\_ 2° Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**PLEASE NOTE: PPD Positive PATIENTS SHOULD BE REFERRED TO WETMORE CLINIC.**

**Please Indicate Reason for Referral (and obtain pre-appointment workup as below):**

- \_\_\_ 793.1 Abnormal CXR, Suspect Neoplasm: Obtain **CT Scan with contrast of Chest and Upper Abdomen, CBC, & CMP (within 30 days of scheduled CT), Calcium, LDH**
- \_\_\_ 793.1 Abnormal CXR, Other (**REFER TUBERCULOSIS TO WETMORE CLINIC**)
- \_\_\_ 496 COPD: Obtain **CXR (PA & Lateral) and Complete PFT's (with ABG if Pulse Ox < 90%)**
- \_\_\_ 786.2 Unexplained Cough: Obtain **CXR (PA & Lateral)** if not already available
- \_\_\_ 786.09 Unexplained Dyspnea: Obtain **CXR (PA & Lateral) and Complete PFT's (with ABG if Pulse Ox < 90%)** if not already available
- \_\_\_ 786.3 Hemoptysis: Obtain **CXR (EPA & LAT), CBC, CMP, Calcium & LDH**
- \_\_\_ 515 Interstitial Lung Disease: Obtain **Complete PFT's (with ABG if RA Pulse Ox < 90%), CBC, CMP, & EKG** if not already available
- \_\_\_ V72.83 Pre-Op Evaluation: Obtain **Complete PFT's, ABG, & EKG (within 6 months) CBC & CMP within 30 days of appointment**
- \_\_\_ 416.0 Pulmonary Hypertension: Obtain **EKG, CXR (PA & LAT), ECHOCARDIOGRAM, & Complete PFT's with ABG**
- \_\_\_ Other ICD: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

**Note: All MRI & CT Scans with contrast require documentation of current BUN/ Creatinine or GFR within 30 days of the performance of the study. (\*\* Metformin/Glucoophage may be taken on the morning of the study but subsequently must be held for 48 hours & repeat renal function evaluation must be performed prior to resumption.)**

Clinical History Relevant to this Referral: \_\_\_\_\_

**\*\*\*Please send copies of IMAGES (NOT REPORTS) from CT studies if not available for viewing on PACS or not performed at MCL.**

Referring Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Referring Service/Clinic: \_\_\_\_\_

**OFFICE USE ONLY:** Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_:\_\_ am/pm.

If not scheduled, Indicate Reason & Recommendation: \_\_\_\_\_

Reviewing Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Rev 02/19/09