



5002 Cowhorn Creek Rd. Phone: 903-614-3006 Fax: 903-614-3522
5730 Summerhill Rd. Phone: 430-200-5864 Fax: 903-306-2624

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 #	
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Appointment Request

Diagnosis

<p align="center">•COWHORN CREEK LOCATION•</p> <p><input type="checkbox"/> First Available <input type="checkbox"/> Malcolm Smith, MD <input type="checkbox"/> George Burgess, APRN, FNP <input type="checkbox"/> Kevin Platt-PA <input type="checkbox"/> Carmen Gatlin, APRN, ANCP</p> <p align="center">•SUMMERHILL LOCATION•</p> <p><input type="checkbox"/> First Available <input type="checkbox"/> Gregory R. White, MD <input type="checkbox"/> Erin E. McCasland, APRN, ACNP <input type="checkbox"/> Kaleigh K. Foster, APRN, FNP <input type="checkbox"/> Kimberly L. Sutton, APRN, FNP</p>	
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•BOTH LOCATIONS SUPPORT GENERAL PULMONOLOGY NEEDS.•
 Malcolm Smith, M.D. has an interest in Sleep Disorders.
 Gregory White M.D. has an interest in Lung Masses and procedures.

***** 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 the corresponding fax numbers above. 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	
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			