APPALACHIAN REGIONAL PULMONOLOGY

a practice of Appalachian Regional Medical Associates

Patient Name________________________________
Date of Birth________________________________
MRUN________________________________
Please Fill in or Affix a Patient Label

Appalachian Regional Pulmonology
870 State Farm Road | STE 100 | Boone, NC 28607

Referral Form

Date:________________ Referring Office Contact Person:________________________________

Referring Physician:________________________________

Telephone #:________________________________ Fax #:________________________________

Reason for Referral:________________________________

PATIENT INFORMATION

Patient Full Name:________________________________

Address:________________________ City:____________ State:____________ Zip:________

Home phone #:________________________ Daytime phone #: ________________________

Last 4 Digits of SSN:____________________ DOB:________________ Gender ☐Male ☐Female

INSURANCE INFORMATION

Insurance Name/Type:________________________________

Group#:________________________ ID#:________________________

MEDICAL HISTORY

Has patient been hospitalized in the last 6 months? ☐Yes ☐No

Has patient had Chest X-ray in the last year? ☐Yes ☐No Where?________________________

Has the patient had a Chest CT in the last 2 years? ☐Yes ☐No Where?________________________

Has the patient seen a pulmonologist before? ☐Yes ☐No When/Where?____________________

Any prior Spirometry or Pulmonology Function tests? ☐Yes ☐No

(Please fax completed form along with copies of the above studies, reports, and pertinent office notes to fax number (828) 386-2201)

APPOINTMENT INFORMATION *(FOR ARP USE ONLY)*

☐Patient aware of appointment ☐Unable to contact patient

Appointment date:________________________ Time:________________ am / pm

Physician:________________________ Location:________________________________

Effective Date: Not Set
Revised Date: 09/23/2019
Form Number: 11588