APPALACHIAN
Regional Medical Associates
A Division of Appalachian Regional Healthcare System
Appalachian Regional Internal Medicine Specialists

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Pulmonology 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) 386-2750)

APPOINTMENT INFORMATION *(FOR ARIMS USE ONLY)*

☐Patient aware of appointment ☐Unable to contact patient

Appointment date:_____ Time:_____ am / pm

Physician:_____ Location:_____

Effective Date: Not Set
Revised Date: 04/13/2017
Form Number: 11193

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