VALLEY ADVANCED LUNG DISEASES INSTITUTE

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Referral Form

Patient Name _____ Patient Date of Birth_____

Patient Street Address _____ City/State/Zip_____

Patient Phone Number _____ Patient Mobile Number_____

Referring Provider Name & Address

_____

Referring Provider Phone _____ Fax _____

Urgent Referral? ☐No ☐Yes If yes, why?

_____

Referral Clerk Name_____ Referral Clerk Contact Number_____

Specific Symptom/Diagnosis For Referral

- ☐ Obstructive Lung Disease:_____
- ☐ Restrictive Lung Disease:_____
- ☐ Interstitial Lung Disease: _____
- ☐ Pulmonary Vascular Disease:_____
- ☐ Pulmonary Nodules/Mass:_____
- ☐ Other:_____

Please Provide the Following Reports to Expedite Scheduling	
Pre-Authorization & Referral Letter	☐No ☐Yes: Please FAX
Insurance Identification Primary and Secondary	☐No ☐Yes: Please FAX Front & Back
Pertinent Health History	☐No ☐Yes: Please FAX
Has patient had pulmonary function tests?	☐No ☐Yes: Please FAX PFTs
Has patient had chest x-rays/thoracic CT?	☐No ☐Yes: Please FAX Recent Report
(Please ensure patient brings images on CD to their consultation with VALDI)	
Has patient had lung biopsies?	☐No ☐Yes: Please FAX Report