PULMONOLOGY REFERRAL REQUEST

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship ___________________

Patient Name: _____________________________________ **Date of Birth:** _____/_____/__________

Parent/Guardian: __________________________________ **Parent Phone:** _________________________

1. Is this an emergent Pulmonary Referral: ☐ No ☐ Yes
   If yes, please contact Dr. Harrison directly at 949-220-0510 or amy.harrison@nbpedpulm.com.

2. Please describe the patient's chief complaint *and include onset and frequency*:

   ____

   ____

To expedite appointment scheduling, please provide the following by FAX to (888) 563-0922:

- ☐ This completed form, patient demographics and insurance card copy
- ☐ Medical records related to the chief complaint. Lab and test reports from the last year including respiratory cultures, pulmonary function and allergy testing/immune testing if applicable

Referring Provider Name: ____________________________ Phone: _______________ Fax: _________________

Provider Address: ____

City: ____ Zip: ____________________________

Provider Signature: ___________________________________ **Date:** ________________ Time: _______________

Referrals may also be sent via P2P in eClinicalWorks EHR

AMY HARRISON, MD, FAAP

1501 Superior Avenue, Suite 202 | Newport Beach, CA 92663-3640

OFFICE (949) 220-0510 | FAX (888) 563-0922 | EMAIL info@nbpedpulm.com