Document Type: Orders/Referral
Subject: MJE Thoracic Clinic Referral Form

DR0088

METHODIST JENNIE EDMUNDSON

Thoracic Clinic Referral Form

Ph: 712-396-7250 Fax: 712-396-7944

Date:_____

Patient Name:_____ **DOB:**_____

Patient Phone Number:_____

Reason for referral:_____

_____

Referring Provider:_____

Referring Office Contact:_____

Referring Office Phone:_____ **Fax:**_____

The referral will be scheduled once **ALL** of the following documents have been received:

- ☐ Completed Referral Form
- ☐ Current Medication List
- ☐ Patients Demographic Page and Insurance Information/Cards
- ☐ Recent Office Notes (within the last year) pertaining to reason for consult
- ☐ CT Chest imaging (images pushed to Methodist by Radiology)
- ☐ Pathology Reports if applicable
- ☐ Pulmonary Function Test (required for surgery consult)
- ☐ Requested Provider: ☐ Sumit Mukherjee, Pulmonology ☐ Thoracic Surgery

Please include any additional scheduling comments (include any **future scheduled tests** or **pending results):**

_____

_____

- ☐ Please check box if patient is aware of referral
- ☐ Interpreter Needed – Language:_____

********** **Thank you for your referral** **********

Appointment Date/Time:_____

*Our office will contact the patient to schedule. A confirmation fax will be sent with appointment information.

1st Attempt:_____ 2nd Attempt:_____ 3rd Attempt:_____

Referring Office Notified: ☐ Faxed Date:_____

Questions? Please call: 712-396-4118

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD