

# Chest Medicine Associates

100 Foden Road, West Building, South Portland, Maine 04106 Telephone:207-828-1122 Fax:207-828-0188

## Request for Specialty Consultation

**Note: Please note that it is the requesting physician's office and/or primary care physician's office responsibility to obtain the patient's medical records and/or diagnostic studies. Please complete the entire form and attach to patient's medical records.**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Reason for Evaluation/Consultation Request: \_\_\_\_\_

Please select if one of the following:

Obstructive sleep apnea is only indication (OSA)  Pre-Surgery Clearance  Bariatric Surgery

Urgency (Please select one):  Within One Week  Within 2-4 Weeks  Next Available Appointment

*If this is an urgent request please call our office*

Requesting Physician M.D./D.O., Nurse Practitioner, Physician Assistant: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Requesting Physician Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

UPIN# \_\_\_\_\_ NPI# \_\_\_\_\_

Name of person providing this information to CMA: \_\_\_\_\_

Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Referral requested from: \_\_\_\_\_ Referral # \_\_\_\_\_

Has the patient ever seen a pulmonologist (lung specialist)

If so Who? When? \_\_\_\_\_

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**If applicable to appointment, please indicate which studies the patient has completed as well as the date and location of where the study was performed and the date your office requested them be sent to us.**

**Note: All outside films/reports can not be hand carried to the office. They must be received prior to the visit.**

## **Chest X-Ray:**

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Date Requested: \_\_\_\_\_

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Date Requested: \_\_\_\_\_

## **CAT Scan:**

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Date Requested: \_\_\_\_\_

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Date Requested: \_\_\_\_\_

## **Pulmonary Function Test (Breathing Test):**

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Date Requested: \_\_\_\_\_

## **Polysomnography (Sleep Study):**

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Date Requested: \_\_\_\_\_

## **Patient Information**

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Only list numbers the patient wishes to be contacted at.

(Home): \_\_\_\_\_  (Day): \_\_\_\_\_  (Cell) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Pt: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Day): \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*To be completed by Chest Medicine Associates Staff:*

Previous Patient: Year Last Seen \_\_\_\_\_ Chart Requested From Storage \_\_\_\_\_

Patient Telephone Interview Date/Staff Member Conducting Interview: \_\_\_\_\_

Physician who will be seeing the patient: \_\_\_\_\_ Appointment Date and Time: \_\_\_\_\_