PATIENT REFERRAL REQUEST

Thank you for referring your patient to MUSC's Pulmonary Division. Please fax the completed request form to **(843) 792-2995** along with relevant medical records. For additional information about our specialties, please visit http://academicdepartments.musc.edu/medicine/divisions/pulmonary/index.htm or call (843) 792-LUNG (5864).

Patient Information

Patient Name (Last, First, Middle Initial)		**Date**
Gender	**Patient preferred language**	
Date of Birth	**Home Telephone Number**	**Alternative Telephone Number**
Home Address		
Insurance Information		

Referring Provider Information

Referring Provider Name (Last, First, Middle Initial)		**NPI**
Referring Provider Contact Telephone	**Referring Provider Contact Fax**	**E-mail Address**
Address		
Patient's Primary Care Provider (if different from above)		

Referral To:

Specialty Clinic Name	**Clinic Location**
Requested Provider	**Referral / Urgency**
Reason for Referral	**Diagnosis**
Additional Information	