



New Patient Referral Form

Please complete form and fax with patient records including the following:
•Progress notes related to diagnosis •Current medication list
•Current chest CT or CXR if applicable •Current PFT's if applicable

OSU Lung Center
2050 Kenny Road, Suite 2200
Columbus, OH 43221
PH: (614) 293-4925
FX: (614) 293-5503

Date: _____ Patient name: _____
(first) (mi) (last)

Patient Address: _____
(street) (city, state) (zip)

Patient home phone number: () _____ () _____
(or)

Patient date of birth: _____

Referring physician: _____ NPI#: _____

Please check below the reason for visit or complete "other" and state reason:

- First Available
- Sarcoidosis
- Pulmonary Hypertension
- Pulmonary Fibrosis/ILD
- Lung Cancer
- COPD or Emphysema Clinic
 - o Evaluation for LVRS
- Other-please specify _____
- Dive Medicine
- High altitude
- Transplant
- Sleep Apnea
- Insomnia
- Narcolepsy
- Asthma
 - o Refractory/steroid dependent
 - o Xolair Evaluation
 - o ICE Program
 - o Athlete/Exercise
 - o Pregnancy

Office Use Only:

Seen by our pulm Dr. before? Yes No If Yes, physician _____

Scheduling complete? Yes No

Medical records received? Yes No

Date & time of appointment: _____

Packet mailed: _____

Physician patient is to see: _____

Please indicate if an interpreter is necessary: Yes No If Yes, language spoken _____