MEADOWS HEALTH
PULMONOLOGY AND SLEEP MEDICINE

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PATIENT INFORMATION

Name:_____ **DOB:**_____

Address:_____

Phone Number(s):_____ **SSN:**_____

Insurance:_____ **Referral Number:**_____

Please fax a copy for demographic sheet and current insurance cards to 912.538.8109

Referring Physician:_____

Physician Phone Number:_____

Reason for Referral:_____

If Surgery Clearance – Surgery Date:_____

Appointment Made On:_____ **By:**_____

Scheduled For:_____

Dear referring Physician,

We would like to sincerely thank you for your referrals. We are pleased to be able to participate in the care of your patients. Patient care is of the utmost importance to us and in order to better serve you and your patients, and to prevent duplicating tests already done, please fax the following with the referral:

- Updated medication list and most recent office note
- Any prior related testing including chest X-rays, CTs, MRIs, PET scans
- Most recent bloodwork

This information will help tremendously when determining what testing patients will need. Should you have any questions or concerns, please feel free to contact our office.