Pulmonary & Critical Care Consultants of Austin, LLP

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Phone 512-459-6599
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NEW PATIENT REFERRAL FORM

CONFIDENTIAL

PATIENT NAME: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

INSURANCE: _____

REFERRING PHYSICIAN: _____

REFERRING PHYSICIAN PHONE: _____

REFERRING PHYSICIAN FAX: _____

REASON FOR REFERRAL: _____

_____

_____

_____

Please send my relevant medical records including:

- History & Physical
- Notes from recent visits
- Imaging reports (CXR, CT scans, PET scans)
- Recent lab data

We prefer to assign new patients based on appointment availability. If evaluation by a particular physician at PCCCA is requested, please note the request below. We will do our best to accommodate your request, but please understand that some of our physicians are not currently accepting new patients into their practices. Also, waiting times for a new patient appointment may be much longer if a particular physician is requested. It may not be possible to accommodate requests in all instances.

Physician Requested:
- ☐ First available
- ☐ Other _____

*** Please fax this completed form to 737-222-5201**