CHEST MEDICINE ASSOCIATES
The Pulmonary • Critical Care • Sleep Medicine Specialists
100 Foden Road, South Portland, Maine 04106
Telephone (207) 828-1122 (Referral line: ext. 108)
Facsimile (207) 828-0188 **www.cmamaine.com**

REFERRAL FORM

Date: _____ Referral to: _____ ☐ Or next available physician in this group

Please send a copy (front and back) of the patient's insurance card(s) or insurance information with this form and a copy of the most recent office note(s) and labs/imaging reports.

Patient Name:_____ D.O.B. _____ Gender: ___M ___F SS#_____
Street Address: _____ City, State, Zip: _____
Patient Phone: Home_____ Work_____ Cell:_____
Patient e-mail:_____
Special Needs: ☐ Interpreter_____ Wheelchair Bound ☐ O2 ☐ Other_____

Referring Provider: _____ Phone# _____ NPI # _____
Referring Provider's Contact Person_____Phone#_____
Patient's Primary Provider, if different_____

NEXT SECTION TO BE FILLED IN BY PROVIDER

Referral:
☐ Next available appointment ☐ Within 2-4 wks ☐ Within 1 wk ☐ **Urgent (within 24 – 48 hrs)** Pr***ovider to call***
Reason for consultation (primary dx or sx): _____
_____
Consultation service requested (check all that applies):
☐ Single consultation for opinion on diagnosis and/or treatment; ***please send patient back to me for follow-up***
☐ Consultation and ongoing co-management of patient with Primary Provider
☐ Please assume primary responsibility for ongoing care related to "reason for consultation"
☐ Testing: _____ ☐ Procedure: _____
Supporting documentation being sent to specialist:
☐ Problem list ☐ Medication list ☐ Allergy list
☐ Referral letter ☐ Office note(s) _____ (dates)
☐ Labs (please send recent reports)_____
☐ Imaging Location/Date_____
☐ Pertinent hospital records _____ ☐ Other: _____
Requests for specialist:
☐ Additional providers to receive copy of this consultation: _____

NEXT SECTION TO BE FILLED IN BY SCHEDULING OFFICE

The Patient's appointment was made within the above requested time frame. Yes No (circle)
Please provide a reason if (NO) was circled: _____ Staff Initials_____
Appt Date: _____ Time: _____ Location: _____ Physician: _____
Patient notified of appointment: Date _____ ☐ In person ☐ Mail ☐ Fax ☐ Phone ☐ Voice mail