MSU SPECIALTY CLINICS -E. LANSING

4660 South Hagadorn, Suite 405, East Lansing, MI 48823

{ }PULMONARY PHONE: 517 884-8600 FAX: 517 432-3694 { } GENETICS

DIAGNOSIS/ICD 10: ____

Infection Type: [ ] None [ ] MRSA [ ] Cepacia [ ] Other _________________ Date of referral:________

[ ] Pulmonary, Allergy & Immunology [ ] Pulmonary Function Test - complete [ ] Methacoline

or secify: **[ ] Spirometry only [ ] Volumes/Resistance [ ] Pre & Post BD [ ] DLCO (Diffusion)**

FAX ALL PERTINENT MEDICAL RECORDS WITH THIS REFERRAL

PATIENT INFORMATION

Patient Legal Name:	Male [ ] Female [ ]	Date of Birth	Social Security Number
Address:			Home Telephone:
City:	State:		Ethnicity:

PARENT/GUARDIAN INFORMATION

Parent/Guardian Legal Name:			Date of Birth	Social Security Number
Address:			Home telephone	Work Telephone:
City:	State:	Zip	Cell Phone:	Place of Employment:
Parent/Guardian Legal Name:			Date of Birth	Social Security Number
Address:			Home telephone	Work Telephone:
City:	State:	Zip:	Cell Phone:	Place of Employment:

EMERGENCY CONTACT **Please give name of someone that lives outside the home**

NAME:	Home Phone:
Relationship to Patient:	Work Phone:

REFERRING PHYSICIAN / PRIMARY CARE PHYSICIAN

Referring Physician Name:	Person completing form:	Office Phone:
Referring Physician Address/City/State/Zip		Office Fax:
PCP Name (if different than Referring Physician:)	City/State	Office Number

INSURANCE INFORMATION - FAX COPY (front and back) OF INSURANCE CARD(S)
APPOINTMENT WILL NOT BE SCHEDULED WITHOUT CURRENT INSURANCE INFORMATION

Primary Insurance Name:		***Secondary Insurance Name:***	
Subscriber:		Subscriber:	
Contract Number:	Group Number:	Contract Number:	Group Number:

INSURANCE AUTH INFORMATION	Authorization Number:	# of Visits Authorized:
Testing Date / Time:	**Appointment Date/Time**	Scheduled by: