Walton Pulmonary
& Sleep Medicine

WE THANK YOU FOR THIS REFERRAL.

Instructions: Please complete and fax to: (770) 466-1585

PATIENT DEMOGRAPHIC/CONTACT INFORMATION

Name:	Date of Birth:
Address:	
Home Phone:	Cell Phone:
Email Address:	

INSURANCE INFORMATION

Primary Insurance:	Insurance Number:
Secondary Insurance:	Insurance Number:

REFERRING DOCTOR INFORMATION

Referring Provider:	Date of Referral:
Fax Number:	Phone Number:

Reason for the Consult/Appointment (Please choose below):

- ☐ Pulmonary Consultation including full body pulmonary function test, as needed- Please indicate reason for consult: _____
- ☐ Sleep Disorder Evaluation and/or Sleep Study, as needed
- ☐ Pulmonary Rehabilitation Program (Loganville Facility Only)
- ☐ Allergy Test (Skin Test)
- ☐ Sleep Apnea Maintenance (CPAP Set-Ups)
- ☐ Oral Appliances for Sleep Apnea
- ☐ Trilogy Ventilation
- ☐ Cardio-Pulmonary Exercise Testing (Conyers Facility Only)
- ☐ Other Diagnostic Testing*: Please indicate type:_____
- ☐ Other (please indicate below):

Please choose a preferred office location for this patient:

- ☐ 101 Tara Commons Drive, Loganville GA 30052
- ☐ 2390 Wall Street SE, Conyers, GA 30013

We will contact your patient to schedule an appointment within 24 hours. We will notify you via fax once this appointment has been scheduled.

***We currently offer the following diagnostic test at our clinic: EKG, ABG, Early CDT and Alpha-1**

For more copies of this form please visit http://www.waltonpulmonary.com/health-care.html