



Children's Hospital
2018 Clinch Avenue
1st Floor South Tower
Knoxville, TN 37916

Pediatric Pulmonology & Respiratory Care Referral Request

PLEASE FAX THIS FORM, ALONG WITH 1) LAST VISIT 2) DEMOGRAPHICS
3) INSURANCE CARD 4) IMAGING REPORTS TO (865) 246-7560.

IT IS THE RESPONSIBILITY OF THE REFERRING PROVIDER TO NOTIFY
THE PATIENT OF THE APPOINTMENT DATE AND TIME.

Referring provider/specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Patient name: _____ Date of birth: _____ M or F

Address: _____ City: _____ State: _____ Zip: _____

SSN#: _____ Parent or guardian: _____

Phone: _____ Cell: _____ Work: _____

Insurance: _____ ID#: _____

Subscriber: _____ Date of birth: _____ SSN#: _____

Employer: _____ Phone: _____

*PLEASE ATTACH A COPY OF THE INSURANCE CARD AND INSURANCE REFERRAL IF REQUIRED.

Reason for referral: _____

Relevant Hx: _____

Any acute illness in the last 30 days? Y or N Date: _____ Diagnosis: _____

Any pneumonia in the last 3 months? Y or N Date: _____

Any neurological delays? Y or N

Patient on oxygen at this time? Y or N

Patient on APNEA Monitor? Y or N

INTERPRETER NEEDED? Yes No

.....FOR PEDIATRIC PULMONOLOGY OFFICE ONLY.....

Appt: date/time: _____

CXR PFT MD ___ NP ___ Provider: _____ SCH by: _____ Mailout: _____