New Patient Referral Form

Ferrell-Duncan Clinic Pulmonology
Wheeler Heart and Vascular Center
3800 S National Avenue, Suite 510, Springfield, MO 65807
Phone: 417-875-3160 Fax: 417-875-3410

REFERRING CLINIC INFORMATION

Referring Clinic Name: Date:
Referring Provider Name: Clinic Contact Name:
Phone: Fax:

PATIENT INFORMATION

Patient Name: Patient Date of Birth:
Home Address:
Home Phone: Cell Phone:
Work Phone: ☐Male ☐Female ☐Other (Specify):
Primary Language: Interpreter Needed: ☐Yes ☐No
Contact Name: Contact Relationship:
1st Insurance: Policy: Group:
2nd Insurance: Policy: Group:
Is this a Work Comp related injury? ☐Yes ☐No
If yes, please complete and fax referral to Work Complete at 417-269-2668
Employer Name/Contact information:

REFERRAL INFORMATION

☐First Available Physician ☐Specific Physician requested (if applicable):
Diagnosis/Complaint:

Chronic? ☐Yes ☐No Date of Injury/Symptoms:
Required Testing: (This list is not exhaustive, so please call if you have questions.)
Asthma, COPD, Cough, Daytime Hypoxia/Hypoxemia, Emphysema, Restrictive Lung Disease, Shortness of breath/DOE, Recurrent Pneumonia: Full PFT (within last 6 mos.)
Lung Mass, Pulmonary Nodule, Hemoptysis, EBUS, Bronchoscopy: Chest CT scan report & image (within last 6 mos.)
Pulmonary Hypertension: Echo, and 6MW
Surgical Clearance: Full PFT (within last 6 mos.) - If none available and unable to complete timely, let office know
Sleep evaluation: Any previous sleep studies done in the past (if applicable)
Post COVID: Call office for current post COVID algorithm and recommendations.
This form must be completed and faxed with the following:

1) All office notes pertaining to the diagnosis/reason for referral
2) Any labs and diagnostic testing/imaging pertaining to the diagnosis/reason for referral
3) Radiology images requested on (date:) by: to be sent via cloud to Cox South Radiology department.
4) Patient medication list
5) Copy of patient's insurance card(s) including front and back and valid photo ID

Fax this completed form to: 417-875-3410

The patient will be scheduled as soon as possible and we will notify you of the appointment date and time.
Appointments will not be scheduled until all records are received.

OFFICE USE ONLY

Appointment Information:

Provider: Date: Time:
Patient notified: ☐ Yes ☐ No Staff Initials: