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THE University of Vermont Children's Hospital

PEDIATRIC PULMONOLOGY

It is our goal to be prepared for your patient's first visit in order to provide them with the best possible care. Please complete this form so we will have all the necessary Information for their visit.

The patient is being referred for:

- ☐ Office visit

Patient name: _____

Date of Birth: _____

Mailing address: _____

Insurance carrier & Certificate number: _____

Is an insurance referral required?_____

Reason for consult: _____

Have any of the following tests been done outside of UVM Medical Center?

- ☐ Chest x-ray; if yes, please attach copy of report, and, if available, please have the x-ray pushed through the PACS system
- ☐ Labs; if yes, Please attach copy of report(s)
- ☐ **No tests** have been done/no tests have been done outside UVM

Please attach last office note, Relevant ER records and previous pulmonary records

Physician requesting consult_____

Phone number: _____ Fax number: _____

Thank you.