Pulmonary / Allergy Consultation Request Form

Patient Name: _____ DOB: _____

Referring MD: _____ Phone: _____ Fax: _____

Type of Consult: □ Emergent (within 1-2 week) □ Routine (within 2-4 weeks)

Requested Specialist: □ ANY □Barker □Sy □ Raza □McGuire □Perkins □Amrol (Allergy/Immunology)

Reason for visit: Evaluation for		Please send if available:
• Dyspnea	• Interstitial Lung Disease	□ List of current Medications
• COPD	• Immunodeficiency	□ Last office note
• Pleural Effusion	• Rhinitis / Sinusitis	
• Asthma	• Rhinitis / Sinusitis	Please send items below if done outside the Palmetto Health System:
• Lung Nodule	• Urticaria / Eczema	□ PFT's
• Lung Mass (>3cm)	• Pre op Evaluation	□ Chest X-rays &/or CT Scans
• Lymphadenopathy or Sarcoidosis	• Hemoptysis	□ Echocardiogram *
• Post-tracheostomy Care		□ Cardiac catheterization*
• Pulmonary Hypertension (please send items with *)		□ V/Q Scan*
• Sleep Disorder (please send items with ŧ)		□ Labs*
• Airway Disease (i.e. stenosis / malacia / polyps / lesions)		□ Sleep Study (if already done) * ŧ
• Other: _____		

Request call / fax from consultant during the visit: □ Y □ N (Dictated notes will be faxed after the visit.)

Please fax this request and records to 799-5890, Attn: Medical Records.

Thank you for referring your patient to USC. For questions call 803-799-5022.