# PFT Patient Referral

Date:_______________

Patient Name:_______________________________________ DOB:________________________________________

Address:_________________________________________________________________________________________

City:_______________________________________________ State:__________________ Zip:_______________

Phone:____________________________________________

Primary Insurance:_________________________________ Secondary Insurance:_________________________

ID#:_____________________________________________ ID#:________________________________________

Group #:__________________________________________ Group #:_____________________________________

Requesting Physician Name:________________________________________________________________________

**Referral Number**:__________________________________ **Primary DX**:_______________________________

**Please Circle the Requested Services:**

| | |
|---|---|
| Spirometry | Lung Volumes |
| Spirometry with Bronchodilator | Methacholine Challenge |
| Diffusion | MIP/MEP |
| Overnight Oximetry | On Room Air / ______LPM |

**URGENT / NEXT AVAILABLE**

If you have any questions please call at 503-588-3945 and ask to speak to a Scheduler.
**Please Fax This Form to 503-588-0256**