DENALI HEALTHCARE SPECIALISTS

PULMONOLOGY REFERRAL FORM

PATIENT PROFILE			
Last Name:	First name:	Date of Birth:	Age: ☐ Male ☐ Female
Address:			
Telephone #:	Alt. Phone #:	Email Address:	
Primary Insurance:		Secondary Insurance:	

REASON FOR PATIENT REFERRAL

SERVICES REQUESTED

	Pulmonary Consultation		
	Full Pulmonary Function Tests (Pre- and post-bronchodilator spirometry, lung volumes, and diffusion test)		
	Pre- and Post-Bronchodilator Spirometry		Spirometry without Bronchodilator
	Diffusion Test (DLCO)		Lung Volumes
	6-Minute Walk Study		Methacholine Challenge Test
	Sleep-Related Disorder Consultation		

Suspicious Symptoms

☐ Observed Apneas
☐ Choking / Gasping (asleep)
☐ Loud Snoring
☐ Excessive Sleepiness
☐ Chronic Fatigue
☐ Drowsy Driving
☐ Morning Headaches
☐ Frequent Awakenings
☐ Leg Restlessness / Jerks
☐ Sleepwalking / Talking
☐ Nocturnal Behaviors
☐ Cataplexy / hallucinations
☐ Other:_____

Suspected Diagnosis

☐ Sleep Apnea
☐ Parasomnias
☐ Narcolepsy
☐ Insomnia
☐ Restless Legs Syndrome
☐ Sleep-related Movement Disorder
☐ Circadian Rhythm Sleep Disorder
☐ Other:
_____

Referring Physician: _____ NPI: _____

Address: _____ Phone:_____ Fax:_____

Special Instructions: _____

Signature: _____ Date: _____

Please fax referral form to us along with patient demographics, insurance card(s), and relevant clinical notes.
Thank you for referring your patient to us!

4048 Laurel Street, Suite 202, Anchorage, AK 99508 **Phone: 907.770.5864 · Fax: 907.770.5868**