Texas Allergy & Breathing Centers

1611 N BELTLINE RD, STE C
MESQUITE, TX 75149

3900 AMERICAN DR. STE 203
PLANO, TX 75075

3142 HORIZON RD #205
ROCKWALL, TX 75032

Phone: (972) 288-3471 Fax: (972) 288-7445

Pulmonary, Allergy, & Sleep Referral Form

PATIENT INFORMATION

Name: ______________________
Address: ______________________
City: State: ______________________
Phone: ______________________
Alt. Phone: __________ ZIP: __________
SSN: ______________________
____
DOB: ______________________

INSURANCE INFORMATION

Carrier: ______________________
Phone: ______________________
Group # ID# ______________________
Person Insured: ______________________
Insured SSN: ______________________
Insured DOB: ______________________
____
____

CLINICAL OBSERVATION

- ○ Abnormal CXR
- ○ COPD
- ○ Shortness of Breath
- ○ Hypoxemia Pneumonia
- ○ Pulmonary Embolism
- ○ Occupational Disease (All)
- ○ Asthma Cough
- ○ Wheezing
- ○ Allergy Evaluation
- ○ Sinusitis
- ○ Sleep Apnea
- ○ Snoring
- ○ Restless Leg Syndrome
- ○ Morbid Obesity
- ○ Other:

REQUESTED TESTING

- ○ Pulmonary Evaluation and Treatment
- ○ Allergy Evaluation and Testing
- ○ Sleep Evaluation and Treatment
- ○ Pulmonary Clearance
- ○ Exercise Evaluation
- ○ Other:

- ☒ I authorize Texas Allergy and Breathing Centers to perform sleep studies on the above patient according to their protocol.
- ○ *I do not authorize Texas Allergy and Breathing Centers to provide follow up, as I will provide the long-term care for this patient.*

PHYSICIAN INFORMATION

Primary Care Physician: ______________________ Phone: ______________________

Ordering Physician: ______________________ Fax: ______________________
○ *Same as above*

Address: ______________________

Physician Signature ______________________ Date: ______________________
Required