Date: ____________________ **RE:**____

NEW PATIENT REFERRAL TO BAY AREA PEDIATRIC PULMONARY

To whom it may concern,

Please review the attached information that we received from your office. We cannot enter the patient into our database for scheduling without the following information:

- □ Need copy of insurance card
- □ Need hard copy of authorization (if required)
- □ Please request CPT codes: 99245 (Consult), 94375 (PFT 6 yrs +), 94760 (O2 sat), 94664 (Teaching)
- □ If for Sleep Clinic, request CPT codes: 99245 (Consult) and 95811 (Sleep study)
- □ Need clinic notes (last two office visits okay)
- □ Patient's preferred language: □ English □ Other: ________________________
- □ Need "New Patient Referral Questionnaire" completed
- □ Doctor demographic information

Diagnostic test determination will be made by the pulmonologist at the time of visit. If you are interested in any testing prior to this visit, please consult with the pulmonologist assigned to the patient.

Please re-submit your request for a new patient appointment with the necessary forms checked above. Thank you in advance for your cooperation.

Bay Area Pediatric Pulmonary
T: (510) 428-3305
F: (510) 597-7154

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