Esther Fields, DO Dominic deKeratry, MD Audrey Nguyen, MD Katherine Wentworth, PA-C

Georgetown Pulmonary Associates, P.A. 1900 Scenic Drive, Ste. 2220 Georgetown, TX 78626 Office (512) 819-0132 Fax (512) 819-9335



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General Pulmonary, Interventional Pulmonary and Critical Care Services

Patient Name:		Date of Birth:	
Phone: ()	Address:		
Primary Insurance Name:		Plan #	
Group # Effective date:		Expiration Date:	
Secondary Insurance Name:		Plan #	
oup # Effective date:		Expiration Date:	
Referring Physician Inform	ation		
Physician Phone: ()			
Physician Fax: () Office Conta		Contact:	
Please Schedule: Urge	nt (please call)	1-2 weeks Within 1 Month	
OR <u>Please Schedule the be</u>	low Diagnostic Test(s):	ICD-10 Diagnosis Code:	
Spirometry (simple) with bronchodilator challenge		Diagnostic Bronchoscopy (Requires Consult)	
Diffusion Capacity (DLCO)		Endobronchial Ultrasound (EBUS)	
Static Lung Volumes		(Requires Consult)	
Drug Toxicity Surveillance (spirometry + DLCO)		Thoracoscopy (Requires Consult)	
Maximum Insp./Exp. Pressures		Tunneled pleural drain (Requires Consult)	
Thoracentesis			