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## PULMANOLOGY REFERRAL FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_  Nursing Instruction Required

Ship to:  Patient  MD Office

Prescriber's Name: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

### PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  F  M

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Email: \_\_\_\_\_

### PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

#### CLINICAL INFORMATION

##### DIAGNOSIS:

- |  |         |  |        |
|--|---------|--|--------|
| <input type="checkbox"/> Primary PAH                   | I27.0   | <input type="checkbox"/> Moderate persistent asthma, uncomplicated | J45.40 |
| <input type="checkbox"/> Secondary PAH                 | I27.2   | <input type="checkbox"/> Severe persistent asthma, uncomplicated   | J45.50 |
| <input type="checkbox"/> Idiopathic Pulmonary Fibrosis | J84.112 | <input type="checkbox"/> Idiopathic urticaria                      | L50.1  |
| <input type="checkbox"/> Other _____                   | _____   | <input type="checkbox"/> Other _____                               | _____  |
| <input type="checkbox"/> Other _____                   | _____   | <input type="checkbox"/> Other _____                               | _____  |

#### PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & STRENGTH	DIRECTION	REFILLS
<input type="checkbox"/> Brovana			
<input type="checkbox"/> Perforomist	<input type="checkbox"/> 20mcg/2ml solution	<input type="checkbox"/> 20mcg/2ml solution vial every 12 hours	
<input type="checkbox"/> Xolair			
<input type="checkbox"/> Nucala	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> 100mg vial injection every 4 weeks	
<input type="checkbox"/> Cinqair	<input type="checkbox"/> 100mg/10ml vial		
<input type="checkbox"/> Ofev	<input type="checkbox"/> 150mg capsule	<input type="checkbox"/> One capsule every 12 hours	
<input type="checkbox"/> Esbriet	<input type="checkbox"/> 267mg <input type="checkbox"/> 801mg	<input type="checkbox"/> One tablet three times a day	
<input type="checkbox"/> Adcirca	<input type="checkbox"/> 20mg tablet		
<input type="checkbox"/> Revatio	<input type="checkbox"/> 20mg tablet <input type="checkbox"/> 10mg/ml oral suspension	<input type="checkbox"/> One tablet three times a day. Doses should be given 4-6 hours apart	

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT NOTICE:** This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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