# Care New England Pulmonary Medicine
# Lung Nodule Clinic Referral

**Fax: (401) 886-7913** **Phone: (401) 886-7910**

Date of referral: _____

Name of patient: _____

Date of birth: _____

Home telephone: _____ Work telephone: _____ Cell telephone: _____

Insurance: _____

Referring physician: _____ Phone number: _____

Primary Care Provider: _____ Phone number: _____

Reason for referral: ☐ Lung Nodule: _____

☐ Lung Mass: _____

☐ Other (please explain): _____

Imaging Studies already performed: Type: _____ Date: _____ Location: _____

Type: _____ Date: _____ Location: _____

Other diagnostic tests performed: _____

_____

Service(s) requested: _____

Referring provider's signature (required): _____

**Please attach:*

- Insurance referral
- Patient demographics
- Last office note
- Related imaging studies

*Office use only*

Appointment(s): _____

Care New England MEDICAL GROUP