Lung Health and Pulmonary Nodule Clinic

Referral Appointment Request Form

Phone: (603) 650-8537
Fax: (603) 727-7499
Address: 1 Medical Center Drive
Lebanon NH 03756
Providers:
Rian Hasson, MD
Elliot Backer, MD
Alexandra Fannin, APRN
Hilary Allison, APRN

Thank you for this referral. Please provide the information requested below to expedite the referral process. **FAX** the completed form **AND** copies of recent office visits, medication and allergy list, relevant lab and diagnostic tests and patient demographics to fax # (603) 727-7499.
We will contact your patient to schedule the appointment.

Patient Information:

Patient Name: ______________________________ Date of Birth (MM/DD/YYYY): ______ / ______ / ______

Address: ____________________________ City: ___________________ State: ____________ Zip: _________

Preferred Phone #: _______________________________

Referring PCP: ____

Referring Provider Information:

Referring Provider (please print): _________________________ Office Phone #: _______________________

Contact Name: ____ Office Fax: _______________________

Address: ____

Please choose the reason for the referral: *select all that apply*
Note: If scheduling LDCT screening ONLY, please use the radiology imaging request form.

- ☐ Shared Decision Making and Smoking Cessation for Lung Cancer Screening *(Clinic completes shared decision making/tobacco cessation with patient AND schedules LDCT screening)*
- ☐ Abnormal Lung Cancer Screening Low-Dose Chest CT Results *(for assistance with Lung-RADS 3-4x scan results)*
- ☐ General Smoking Cessation
- ☐ Abnormal or Incidental Chest or Lung Imaging Findings *(for management of unexpected imaging findings)*
- ☐ Other (please specify)

Patient Tobacco Use History:

☐ Current ☐ Former ☐ Never

If current or former is checked, please fill out the following:

Start Date: _____ /_____ /_____

Packs/Day*: _______________
**note 1 pack = 20 cigarettes*

Years: _______________

Pack-Years (*packs/day x # years*): _______________

Quit Date (*if Former*): _____ /_____ /_____

Please check which information below is included with this referral:

☐ Pertinent office notes	☐ Medication List	☐ Labs	
☐ Tobacco History	☐ Pulmonary Function Tests	☐ Additional Diagnostic Tests	
☐ Surgical/Endoscopy Notes	☐ Pathology Reports		
☐ Imaging:	☐ X-ray	☐ CT Scan	☐ PET Scan
☐ Other (please specify): _______________			