MLA | MASS LUNG & ALLERGY PC

Section 1: Patient Information

Patient Name:_____DOB:_____Sex:_____

Address:_____Apt:_____

City:_____State:_____Zip Code:_____

Phone (Primary):_____Phone(Secondary):_____

Insurance Co:_____Subscriber ID:_____

Secondary Insurance:_____Subscriber ID_____

Section 2: Referral Type

☐ Pulmonary Medicine
Reason for referral:

☐ Sleep Medicine
Reason for referral:

☐ Allergy/Allergy Testing (Worcester office only)
Reason for referral:

☐ Home Sleep Testing (please fill out clinical data sheet)

Please include recent office notes, relevant imaging and sleep study results with referrals

Section 3: Preferred Location

☐ Leominster Office
100 Hospital Rd, Ste. 2A
Ph: 978-798-6900
Fax: 978-798-6909

☐ Worcester Office
85 Prescott St, Ste. 302
Ph: 774-420-2611
Fax: 774-420-2616

☐ Concord Office
131 ORNAC, Ste. 410
Ph: 978-341-8660
Fax: 978-341-8658

☐ Charlton Office (limited schedule)
10 North Main St.
Ph: 774-420-2611
Fax: 774-420-2616

☐ Marlborough Office (limited schedule)
Ph: 774-389-2100
Fax: 774-389-2111

Section 4: Referring Provider Information

Provider Name:_____Date:_____

Provider Signature:_____Contact Person:_____

Office Phone:_____Office Fax:_____