

*Pulmonary and Sleep
Associates of Marin*



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CONSULTATION REQUEST

Patient's Name: _____ DOB: _____ Male ___ Female ___

Phone(s): _____ Address: _____

Referring Physician's name: _____ Phone: _____ Fax: _____

Email: _____

Reason for Consultation: _____

Urgency: ___ routine ___ urgent

Pulmonary Consultation: ___ Dr. Soto ___ Dr. Massoumi ___ either

Sleep Consultation: ___ Dr. Soto ___ Dr. Sepulveda ___ either

Please provide the following documents if available:

1. Recent chest films and PFT reports
2. Sleep Study reports
3. Recent office visit notes
4. Medication list
5. Patient's contact and Insurance information.

Referring Physician's Signature

Date