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 ☐ Dr Tadros

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