Legacy Health Cardiopulmonary

Physician Referral Form

Check one location for your referral

- ❍ Legacy Emanuel Medical Center • Phone: 503-413-4169 • Fax: 503-413-2080 *(EM)*
- ❍ Legacy Good Samaritan Medical Center • Phone: 503-413-7141 • Fax: 503-413-6780 *(GS)*
- ❍ Legacy Meridian Park Medical Center • Phone: 503-692-7415 • Fax: 503-692-2477 *(MP)*
- ❍ Legacy Mount Hood Medical Center • Phone: 503-674-1289 • Fax: 503-674-1281 *(MH)*
- ❍ Legacy Salmon Creek Medical Center • Phone: 360-487-3250 • Fax: 360-487-3259 *(SC)*

Patient name _____ Date of birth *(mm/dd/yyyy)* _____ Age _____

Phone _____ Fax _____

Address _____ Insurance _____

City _____ State _____ Zip Code _____ ICD9/10 — Description _____

Phone _____ Patient Language _____

Pulmonary testing

- ☐ PFT Complete (Plethysmography+DLCO+Spirometry Pre & Post)
- ☐ PFT Pre-Only (Plethysmography+DLCO+Spirometry Pre-Only)
- ☐ Spirometry Pre & Post
- ☐ Spirometry
- ☐ Arterial Blood Gas (ABG)
- ☐ MIP and MEP
- ☐ Other _____
- ☐ PFT Methacholine Challenge
- ☐ Exercise Induced Asthma Study *(EM only)*
- ☐ Oximetry Resting
- ☐ Oximetry Exercise
- ☐ Overnight Oximetry *(MP only)*
- ☐ 6-Minute Walk
- ☐ Metabolic Study *(GS & EM only)*
- ☐ Pulmonary Stress Test Complex *(GS only)*

Cardiac testing

- ☐ Cardiac Event Monitor *(14 days)*
  Other _____
- ☐ 24 Hr Holter Monitor
- ☐ 48 Hr Holter Monitor
- ☐ EKG 12 Lead
- ☐ Pediatric EKG 15 Lead

☐ Cardiac Stress Test	❍ Treadmill	❍ Bicycle
☐ Cardiac Nuclear Stress Test	❍ Treadmill	❍ Bicycle
☐ Cardiac Nuclear RX Stress Test	❍ Lexiscan	❍ Dobutamine *(GS & MP only)*

Contact Imaging Scheduling to schedule a Cardiac Nuclear Stress
Phone: 503-413-7800 Fax: 503-413-8899

Echocardiology

- ☐ Echocardiogram Complete
- ☐ Echocardiogram Limited *(follow-up to complete)*
- ☐ Cardiac Stress Echocardiogram ❍Treadmill ❍Bicycle
- ☐ Cardiac RX Stress Echocardiogram (Dobutamine) *(GS & MP only)*
- ☐ Transesophageal Echocardiogram
- ☐ Congenital Echocardiogram Complete *(EM & SC only)*
- ☐ Congenital Echocardiogram Limited *(follow-up to complete)*
- ☐ Congenital Stress Echocardiogram *(EM only)*
- ☐ Other

Referring physician _____ Phone _____ Fax _____

Physician Signature _____ Date _____

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