

Send Form and Records to:
[IntMed-Puim-
 CallCenter@med.umich.edu](mailto:IntMed-Puim-CallCenter@med.umich.edu)
 Or Fax to: 734-998-2517

Division of Pulmonary & Critical Care Medicine
 1500 East Medical Center Drive
 Ann Arbor, MI 48109-0361
 Office: 888-287-1084
 Fax: 734-998-2517

Today's Date: _____

Patient Demographic Information

Patient Last Name:		Patient First Name:	
Street Address:	City:	State:	Zip:
Home Phone:		Cell Phone:	
Patient Sex assigned at birth:		Patient Gender:	
Main Contact Name (if not patient):		Main Contact Phone:	
Primary Insurance Company:			
Date of Birth:			

Physician Information

Referring Physician Name:			
Office Contact Name:			
Address:	City:	State:	Zip:
Phone:		Fax:	
Primary Care Physician Name (if different than referring physician):			
Address:	City:	State:	Zip:
Phone:		Fax:	

If referring to a specific provider, please note: _____

SELECT THE PATIENT'S PRIMARY DIAGNOSIS AND ANSWER ANY APPLICABLE QUESTIONS

Check appropriate category

	General Pulmonary	<i>Referring Diagnosis / Comments:</i>
	Assisted Ventilation Clinic (AVC)	<i>Referring Diagnosis / Comments:</i>
	<p>Asthma</p> <ul style="list-style-type: none"> • Has the patient had an ER visit or hospitalization related to asthma in the past 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN • Does the patient require maintenance oral corticosteroids (OCS) or had 2 or more exacerbations in the past 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN • Is the patient currently using biologic therapy for asthma or is referral for consideration of biologic therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN • Is the patient still symptomatic despite high dose inhaled corticosteroid (ICS)/long-acting beta agonist (LABA)? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN 	
	<p>COPD</p> <ul style="list-style-type: none"> • Has the patient had 2 or more exacerbations in the last year? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN • Is the patient currently hospitalized or been hospitalized in the last year for a COPD exacerbation? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN • Is the referral to consider advanced therapeutic options for severe COPD (lung volume reduction surgery, endobronchial valves)? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN 	
	Cystic Fibrosis (CF)	<i>Comments:</i>
	Cystic Lung Disease / LAM	<i>Referring Diagnosis / Comments:</i>
	Interstitial Lung Disease (ILD)	<i>Referring Diagnosis / Comments:</i>
	<p>Interventional Pulmonology</p> <p><input type="checkbox"/> Malignant</p> <p><input type="checkbox"/> Non-malignant</p> <p><input type="checkbox"/> Pleural</p>	<p><i>Referring Diagnosis / Comments:</i></p> <p>Please use the Interventional Pulmonology form, located here: http://www.med.umich.edu/pdf/IP-Referral-Form.pdf</p>
	Lung Nodule / Mass	<p><i>Referring Diagnosis / Comments:</i></p> <ul style="list-style-type: none"> • Does the patient have a 4mm or larger pulmonary nodule or growing nodule? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
	Post – COVID Pulmonary Symptoms	<i>Comments:</i>
	<p>PULSE / Post-ICU</p> <ul style="list-style-type: none"> • Was the patient hospitalized in the ICU at Michigan Medicine (or another hospital) in the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN 	