PULMONARY INTERSTITIAL LUNG DISEASE REFERRAL FORM:

UPSTATE
MEDICAL UNIVERSITY

Pulmonary Department @ UHCC
90 Presidential Plaza
Syracuse, NY 13202

Contact Scheduler:
Jenna McIntyre
Phone:315-464-3893
Fax: 315-464-3847

Program Coordinator:
Kristie Garcia, RN
Phone: 315-464-3132
Email: GarciaK@upstate.edu

ATTENTION: ILD Scheduler FAX#: 315-464-3847
Date: _____

Patient's Name:_____

Patient's DOB:_____

Patient's Contact number:_____

Referring Doctor & Contact Information: _____

Thank you for referring your patient to the Interstitial Lung Disease Program at Upstate Pulmonary Department at Upstate Health Care Center (UHCC).

Prior to scheduling your patient for an initial appointment, we will review your patient's records. To ensure prompt review and scheduling, please include the following records with initial referral:

____ Patient demographics

____ Patient insurance information

____ Most recent clinical notes with medication list

____ Pulmonary Function Tests completed within 1 year

____ Any chest x-rays or CT reports. Including images.

____ If possible any autoimmune serology

Please share this information with any office staff that may be responsible for placing referrals.

Please note any follow up questions or inquiries please do not hesitate to contact our office to further discuss.

Respectfully,

Dr Markus Gutsche

Dr Dana Savici

Interstitial Lung Disease Program