SERVICE REQUISITION FORM

Please FAX completed form to: (713) 588-8980

Office Telephone: (713) 568-8887

Texas Pulmonary and Sleep Clinic, P.A.

George Nassif, M.D.

Patient's Name: _____ **Date of Birth:** _____

SS #: _____ **Patient's Phone #:** _____

Primary Insurance: _____ (HMO or PPO) Auth #: _____ EXP. Date: _____

Secondary Insurance: _____ (HMO or PPO) Auth #: _____ EXP. Date: _____

Requesting Physician:

Name: _____ **PH #:** _____

Address: _____ **Fax #:** _____

Physician signature: _____ **Date:** _____

PLEASE ATTACH A COPY OF ANY DIAGNOSTIC TESTING IF AVAILABLE

Reason for Consultation:

☐ Sleep Disorder Evaluation

Symptoms: _____

_____

☐ Pulmonary Evaluation

Symptoms: _____

_____

Please Schedule: ☐ **Urgent** ☐ **Non-urgent**

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