Greenlane
Medical Specialists

*Patient label*

# REFERRAL FORM FOR BRONCHOSCOPY

**Patient Details:**

General Practitioner: _____

Email Address: _____

Contact Number: _____

Insurance Company: _____

**Clinical Indications:**

_____

_____

_____

**Relevant Medical History/Medications:**

_____

_____

_____

**Proposed Procedure:**

☐ Bronchoscopy ☐ Bronchoscopy + BAL ☐ Bronchoscopy + Biopsy ☐ Endobronchial Ultrasound (EBUS)

**Available Date and Time:**

| | | |
|---|---|---|
| ☐ Monday | 12:00PM | Date:_____ |
| ☐ Tuesday | 12:00PM | Date:_____ |
| ☐ Wednesday | 12:00PM | Date:_____ |
| ☐ Thursday | 12:00PM | Date:_____ |

*Note: Patient admission at 11:30am*

**Referrer Details:**

Referrer Name: _____

Email Address:_____

Contact Number: _____

Date: _____

Greenlane Medical Specialists
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