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

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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