Fort HealthCare
For Health

Thoracentesis Referral Form

Complete and return to Surgical Associates via **fax (920) 563-0258.** Outside Fort HealthCare referring providers – please also fax health history (medication list, clinic note, problem list, allergy list).

Patient name: _____ DOB: _____

Address: _____ City: _____

Daytime Phone:_____ Cell Phone: _____

Referring MD: _____ Primary MD: _____

Pertinent patient history information

Diagnosis/ ICD10 and description:

_____

_____

Is patient currently on anticoagulant therapy? Yes____ No ____

If yes, medication name: _____

Can they hold anticoagulation medication prior to procedure? Yes____ No ____

Date of most recent chest xray:_____

Thoracentesis - Therapeutic

- ☐ PRN
- ☐ One Time
- ☐ Right
- ☐ Left
- ☐ Bilateral

Thoracentesis - Diagnostic

- ☐ PRN
- ☐ One time
- ☐ Right
- ☐ Left
- ☐ Bilateral
- ☐ LDH
- ☐ Protein
- ☐ Cell Count
- ☐ Gram Stain
- ☐ Culture
- ☐ Cytology
- ☐ Glucose
- ☐ pH

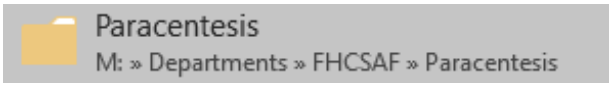
Requesting Physician Signature: _____Date: _____

Surgical Associates use only

Date of procedure:_____ Performing surgeon: _____

Fax to: ☐ Radiology ☐ Ambulatory ☐ Surgical Coordinators ☐ Lab ☐ Pharmacy

Scheduled by:_____ Patient notified_____



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