Greenlane
Medical Specialists

Referral Form

Ga1-2/93-95 Ascot Avenue, Greenlane, Auckland 1051
Ph: (09) 930-6108 | Fax: (09) 930-6109 | bronchoscopy@glms.co.nz

Patient Details:

[Patient Label]

Patient E-mail: ______________________

GP: ______________________

Insurance Company: ______________________

Clinical Indication:

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Relevant Medical History and Medications:

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Proposed Procedure:

☐ Bronchoscopy ☐ Bronchoscopy + BAL ☐ Bronchoscopy + Biopsy

Available Date and Time:

☐ Monday	12:00 PM	Date: ______
☐ Tuesday	12:00 PM	Date: ______
☐ Wednesday	12:00 PM	Date: ______
☐ Thursday	12:00 PM	Date: ______

Note: Patient admission at 11:30am

Referrer Details

Referrer: ______________________ **Mobile:** ______________________

Email: ______________________ **Date:** ______________________