

**EASY FAX PULMONARY REFERRAL**  
**PULMONARY & CRITICAL CARE CONSULTANTS, INC.**  
**WWW.PULMCARE.COM**

**Centerville Office:**  
 MVH – South Campus  
 2300 Miami Valley Dr. #370  
 Centerville, OH 45459  
 (P) 937-461-5815  
 (F) 937-461-2896

**Dayton Office:**  
 InterMed Building  
 1520 South Main Street #2  
 Dayton, OH 45409  
 (P) 937-461-5815  
 (F) 937-461-2896

**Troy Office:**  
 UVMC  
 3130 N Co Rd 25-A  
 Troy, OH 45373  
 (P) 937-552-7038  
 (F) 937-461-2896

**Please fax completed request & reports listed below to expedite scheduling**

Date \_\_\_\_\_

Patient \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Insurance \_\_\_\_\_ ID# \_\_\_\_\_  
Please fax referral or authorization if required.

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Requesting Dr. \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Contact \_\_\_\_\_

- |  |       |   |       |
|--|-------|---|-------|
| <i>First available/No preference</i>         | _____ | <i>Murthy V. Gollamudi, MD, FCCP, D, ABSM</i> | _____ |
| <i>Steven L. Chambers, MD, FCCP</i>          | _____ | <i>Timothy R. Hauser, MD</i>                  | _____ |
| <i>Jennifer K. Clune, MD</i>                 | _____ | <i>Gabriel J. Hays, DO</i>                    | _____ |
| <i>M. Mazen Dallal, MD, FCCP, D, ABSM</i>    | _____ | <i>Soumitra Sen, MD</i>                       | _____ |
| <i>Thomas J. Donnelly, MD, FCCP</i>          | _____ | <i>Emily Speelmon, MD, PhD</i>                | _____ |
| <i>Dharmesh V. Gandhi, MD, FCCP, D, ABSM</i> | _____ |   |       |

Reason for referral \_\_\_\_\_  
(Please fax: PFT's, CXR's, CT chest, Echo, Stress, EKG, Labs, Last 3 office notes, & anything else useful)

**\*We will contact your patient to schedule and notify your office\***

**OFFICE USE ONLY**

Scheduled with \_\_\_\_\_ Appt. Date/Time/Arrival \_\_\_\_\_

Previous Testing			
CXR	_____	LOC _____	Date called _____
CT	_____	LOC _____	Date called _____
PFT	_____	LOC _____	Date called _____
MCT	_____	LOC _____	Date called _____
ECHO	_____	LOC _____	Date called _____
STRESS	_____	LOC _____	Date called _____
SLEEP TESTING	_____	LOC _____	Date called _____

Medical History \_\_\_\_\_

Previous Admit \_\_\_\_\_

Office Testing                      CXR                      PFT                      PFT P/P                      EX OX – RA / O2

Faxed \_\_\_\_\_ Mailed \_\_\_\_\_ Online \_\_\_\_\_ Copied \_\_\_\_\_ Initials \_\_\_\_\_