

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 – North Campus
 3130 N Co Rd 25-A #203
 Troy, OH 45373
 (P) 937-461-5815
 (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 _____
 Primary Care Dr. _____ Phone _____ Fax _____

- | | | | |
|---|-------|--------------------------------|-------|
| <i>First available/No preference</i> | _____ | | _____ |
| <i>Jennifer K. Clune, MD</i> | _____ | <i>Gabriel J. Hays, DO</i> | _____ |
| <i>M. Mazen Dallal, MD, FCCP, D, ABSM</i> | _____ | <i>Vincent W. Kang, DO</i> | _____ |
| <i>Dharmesh V. Gandhi, MD, FCCP, D, ABSM</i> | _____ | <i>Matthew T. Koroscil, MD</i> | _____ |
| <i>Murthy V. Gollamudi, MD, FCCP, D, ABSM</i> | _____ | <i>Soumitra Sen, MD</i> | _____ |
| <i>Timothy R. Hauser, MD</i> | _____ | <i>Emily Speelmon, MD, PhD</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	_____
PET	_____	LOC	_____	Date called	_____
PFT	_____	LOC	_____	Date called	_____
MCT	_____	LOC	_____	Date called	_____
ECHO/STRESS	_____	LOC	_____	Date called	_____
SLEEP Test/CPAP/DME	_____	LOC	_____	Date called	_____

Collaborating Medical Groups

ENT/Gastro (GI)	_____	Last seen	_____
Pulm/Allergist	_____	Last seen	_____
Cardiologist	_____	Last seen	_____

Medical History

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

Faxed _____ Mailed _____ Online _____ Copied _____ Initials _____