FAX REFERRAL FORM

FAX FORM TO: (937) 439-3786

Today's Date: _____

Please Schedule an appointment:

- ❒ **Urgent (call 439-1154)** ❒ **First Available Appointment**
- ❒ **First Available Physician**
- ❒ **Rubio** ❒ **Shah** ❒ **Iberico** ❒ **Razi** ❒ **Ali**
- ❒ **PFT, only** ❒ **Pre-Op Clearance** ❒ **Sleep Disorder Assessment (Fax to 937-395-8821)**

Referred By: _____ Phone: _____

Your Fax: _____

Your Office Contact Name: _____

Reason for Referral: _____

Patient's Name: _____ DOB: _____

Patient's Address: _____

City: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Patient's Insurance: _____ ❒ Referral Required

Last 4 Digits Patient's Social Security Number: XXX-XX- _____

FAX all pertinent medical records, i.e., labs, x-ray reports, etc. to (937) 439-3786

PLEASE ORDER A CHEST X-RAY if one has not been done in the past 12 months.

Scheduled Appointment:

❒ **Kettering**

Date: _____ Time: _____ Doctor:_____ ❒ **Sycamore**

Initial: _____

(rev 1/14)